ROBERT V. EYE LAW OFFICE, L.L.C.
SUITE 1010
4840 BOB BILLINGS PARKWAY
LAWRENCE, KANSAS 66049
PH. 785-234-4040
FAX 785-749-1202
bob@kauffmaneye.com

January 23, 2018

Clerk of the Appellate Courts
Kansas Supreme Court
301 SW 10th Avenue
Topeka, Kansas 66612-1507

Re: *Hodes & Nauser, M.D.s, P.A., et al. v. Derek Schmidt, et al.*, No. 114,153

Dear Clerk of the Appellate Courts:

Pursuant to Rule 6.09(b), Respondents respectfully notify the Court of the following persuasive authority:

> ***Whole Woman's Health v. Paxton*, No. A-17-CV-690-LY, 2017 WL 5641585 (W.D. Tex. Nov. 22, 2017) (attached), *appeal filed*, No. 17-51060 (5th Cir. Dec. 1, 2017)**
>
> ***West Alabama Women's Center v. Miller*, No. 2:15CV497-MHT, 2017 WL 4843230 (M.D. Ala. Oct. 26, 2017) (attached), *appeal filed*, No. 17-15208 (11th Cir. Nov. 22, 2017)**
>
> ***Hopkins v. Jegley*, No. 4:17-cv-00404-KGB, 2017 WL 3220445 (E.D. Ark. (attached), *appeal filed*, No. 17-2879 (8th Cir. Aug. 28, 2017).**

These cases involve constitutional challenges to statutes in Texas, Alabama, and Arkansas that—like S.B. 95, the law at issue in the instant appeal—effectively ban dilation and evacuation (D&E) abortion procedures. This authority supplements the arguments on pages 23-25 of Respondents' Supplemental Brief. There Respondents argue that S.B. 95 imposes an unconstitutional undue burden because the alternatives proposed by the State to induce fetal demise are extreme and unreasonable, and have no established medical benefits.

In *Paxton* the court permanently enjoined enforcement of Texas' ban on D&E. The court found that the state's proposed fetal-demise methods of digoxin injection, potassium chloride injection, and umbilical-cord transection—identical to those proposed by the State in this case—were not feasible and substantially burdened women's federal right to abortion. 2017 WL 5641585, at *9-12.

In *Miller*, the court permanently enjoined enforcement of Alabama's D&E ban. 2017 WL 4843230, at *1. The court closely examined the burdens imposed by the same proposed fetal-demise methods, each of which the court found unfeasible, *id.* at *15-26, and held that the law constituted an unconstitutional undue burden on access to abortion, *id.* at *31.

In *Hopkins*, the court preliminarily enjoined Arkansas' ban on D&E, finding that the State's proposed alternatives, including digoxin injection, potassium chloride injection, and umbilical cord transection, were not feasible, and held that the plaintiffs were likely to succeed on the merits of their claim that the ban imposed an unconstitutional undue burden on women's federal due process right to abortion. *Hopkins*, No. 4:17-cv-00404-KGB, 2017 WL 3220445, at *1, 24-29.

Respectfully submitted,

/s/ Robert V. Eye

Robert V. Eye, KS Bar #10689
Robert V. Eye Law Office, LLC
4840 Bob Billings Parkway, Suite 1010
Lawrence, KS 66049
(785) 234-4040
(785) 234-4260 Fax
bob@kauffmaneye.com

Erin Thompson, KS Bar #22117
Morgan Pilate
926 Cherry St.
Kansas City, MO 64106
(816) 471-6694
(816) 472-3516
ethompson@morganpilate.com

Lee Thompson, KS Bar #08361
Thompson Law Firm, LLC
106 E. Second St.
Wichita, KS 67202
(316) 267-3933
(316) 267-3901 Fax
lthompson@tslawfirm.com

Teresa A. Woody, KS Bar #16949
The Woody Law Firm PC
1621 Baltimore A venue
Kansas City, MO 64108
(816) 421-4246
(816) 471-4883 Fax
teresa@woodylawfirm.com

Janet Crepps, AK Bar #8407062, SC Bar #15902*
(864) 962-8519
jcrepps@reprorights.org
Genevieve Scott, NY Bar #4922811*
(917) 637-3605
gscott@reprorights.org
Zoe Levine, NY Bar #4813705*
(917) 637-3639
zlevine@reprorights.org
Center for Reproductive Rights
199 Water Street, 22nd Floor
New York, NY 10038
(917) 637-3666 Fax

* Admitted Pro Hac Vice

Counsel for Respondents

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was sent via electronic mail on the 23rd day of January, 2018, addressed to the following:

Sarah E. Warner
Stephen R. McAllister
Shon D. Qualseth
Thompson Ramsdell Qualseth & Warner PA
333 W. 9th Street
P.O. Box 1264
Lawrence, KS 66044-2803
(785) 841-4554
(785) 841-4499 Fax
shon.qualseth@trqlaw.com
stevermac@fastmail.fm
sarah.warner@trqlaw.com

Jeffrey A. Chanay
Chief Deputy Attorney General
Dennis D. Depew
Deputy Attorney General, Civil Lit. Div.
Office of KS AG Derek Schmidt
Memorial Building, 3rd Floor
120 S.W. 10th Avenue
Topeka, KS 66612-1597
(785) 368-8435 Phone
(785) 291-3767 Fax
jeff.chanay@ag.ks.gov
dennis.depew@ag.ks.gov

Kimberly A. Parker
Skye L. Perryman
Brittani Kirkpatrick Ivey
Souvik Saha
Wilmer Cutler Pickering Hale & Dorr, LLP
1875 Pennsylvania Ave., N.W.
Washington, D.C. 20006
kimberly.parker@wilmerhale.com
skye.perryman@wilmerhale.com
brittani.ivey@wilmerhale.com
souvik.saha@wilmerhale.com

Don P. Saxton
Saxton Law Firm, LLC
1000 Broadway, Suite 400
Kansas City, MO 64105
don@saxtonlawfirm.com

Mary Ellen Rose
10308 Metcalf Ave., #182
Overland Park, KS 66212
mercat@aol.com

Paul Benjamin Linton
Special Counsel
Thomas More Society
921 Keystone Ave.
Northbrook, IL 60062
pblconlaw@aol.com

/s/ Robert V. Eye
Robert V. Eye, KS Bar #10689

2017 WL 5641585
Only the Westlaw citation is currently available.

United States District Court,
W.D. Texas, Austin Division.

WHOLE WOMAN'S HEALTH, Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood South Texas Surgical Center, Alamo City Surgery Center PLLC, d/b/a Alamo Women's Reproductive Services, Southwestern Women's Surgery Center, Nova Health Systems, Inc. d/b/a Reproductive Services, Each on Behalf of Itself, its Staff, Physicians, and Patients, Robin Wallace, M.D., Bhavik Kumar, M.D., M.P.H., and Alan Braid, M.D., Each on their Own Behalf and on their Patients' Behalf, Plaintiffs,

v.

Ken PAXTON, Attorney General of Texas, in His Official Capacity, and Margaret Moore, District Attorney for Travis County, Nicholas LaHood, Criminal District Attorney for Bexar County, Jaime Esparza, District Attorney for El Paso County, Faith Johnson, District Attorney for Dallas County, Sharen Wilson, Criminal District Attorney Tarrant County, Ricardo Rodriguez, Jr., Criminal District Attorney for Hidalgo County, Abelino Reyna, Criminal District Attorney for McLennan County, and Kim Ogg, Criminal District Attorney for Harris County, Each in their Official Capacity, Defendants.

CAUSE NO. A–17–CV–690–LY

Signed 11/22/2017

Synopsis

Background: Providers of abortion services brought action for declaratory and injunctive relief against Texas Attorney General and county district attorneys, challenging constitutionality of Texas statute imposing civil and criminal penalties on physicians who performed a standard dilation and evacuation procedure (standard D&E) for a second-trimester abortion without first ensuring fetal demise in utero.

[Holding:] After bench trial, the District Court, Lee Yeakel, J., held that challenged Texas statutes imposed an undue burden upon a woman's right to have an abortion before fetal viability, and thus, the statutes were facially unconstitutional.

Declaratory and injunctive relief granted.

West Codenotes

Held Unconstitutional

Tex. Health & Safety Code Ann. §§ 171.151, 171.152, 171.153, 171.154

Attorneys and Law Firms

Amber Dorothy Shubin, Morrison & Foerster LLP, McLean, VA, J. Alexander Lawrence, Morrison & Foerster, LLP, Melissa A. Cohen, Jennifer Keighley, Planned Parenthood Federation of America, Autumn Katz, Caroline Sacerdote, Christine Parker, Genevieve Scott, Hillary Schneller, Janet Crepps, Jenny, Ma, Jessica Sklarsky, Julie Rikelman, Madeline Michelle Gomez, Molly Duane, Rabia Muqaddam, Zoe Levine, New York, NY, David P. Brown, Brooklyn, NY, Patrick J. O'Connell, Law Offices of Patrick J. O'Connell PLLC, Austin, TX, for Plaintiffs.

Adam Arthur Biggs, Andrew Bowman Stephens, Benjamin S. Walton, Heather Gebelin Hacker, John S. Langley, Summer R. Lee, Christopher D. Hilton, Office of the Attorney General of Texas, Darren L. McCarty, Office of Texas Attorney General Executive Administration, Emily L. Ardolino, Laurie R. Eiserloh, Austin, TX, Josephine L. Ramirez, Edinburg, TX, for Defendants.

MEMORANDUM OPINION INCORPORATING FINDINGS OF FACT AND CONCLUSIONS OF LAW

LEE YEAKEL, UNITED STATES DISTRICT JUDGE

*1 Before the court is the above-styled and numbered action by which Plaintiffs, all providers of second-trimester abortion services in Texas, challenge the constitutionality of recently enacted Texas abortion laws.[1] *See* 42 U.S.C. § 1983. The laws at issue regulate second-trimester abortion procedures and are included in Texas Senate Bill 8, Section 6, which, *inter alia*, creates a new Subchapter G in the Texas Health and Safety Code. *See* Act of May 26, 2017, 85th Leg., R.S., ch. 441, § 6, 2017 Tex. Sess. Law Serv. 1167–68 (West) (to be codified at Tex. Health & Safety Code Ch. 171, Subchapter G, §§ 171.151–.154) (the "Act").[2]

Plaintiffs allege that the Act's requirement that Texas physicians ensure fetal demise *in utero* before performing the evacuation phase of a standard D & E abortion, which nationally is the most commonly performed second-trimester abortion, is a substantial obstacle to a woman's exercise of her right to choose a lawful previability second-trimester abortion.[3] Therefore, Plaintiffs claim, the Act is unconstitutional, and, accordingly, the court must declare the Act is void and order injunctive relief to prevent Defendants from enforcing the Act.

Defendants respond that the Act does not place an undue burden on a woman seeking a second-trimester abortion. Rather, say Defendants, the Act's requirement that a physician ensure fetal demise is an appropriate regulation of an abortion procedure. Specifically, Defendants argue that the Act is narrowly drawn, regulates the moment of fetal demise—the lethal act—and does no more than provide for a humane termination of fetal life. The Act, Defendants urge, is therefore a proper mechanism by which the State of Texas may express profound respect for the life of the unborn.

*2 Following a hearing at which all parties were represented by counsel, the court rendered a Temporary Restraining Order ("Temporary Order"). *Whole Woman's Health v. Paxton*, No. 1:17–CV–690–LY, ---- F.Supp.3d ----, 2017 WL 3814835 (W.D. Tex. Aug. 31, 2017). The Temporary Order enjoined Defendants as well as their employees, agents, and successors in office from enforcing the Act.[4] Following rendition of the Temporary Order, the parties informed the court that they agreed to: (1) forego arguing a preliminary injunction; (2) extend the effectiveness of the Temporary Order; (3) conduct discovery; and (4) proceed to a bench trial on the merits. The court considered the parties' agreement, ordered the Temporary Order extended through November 22, 2017, and set this case for trial to the bench. *Whole Woman's Health*, No. 1:17–CV–690–LY (W.D. Tex. Sept. 11, 2017).

On November 2, 2017, the court commenced a bench trial that concluded on November 8, 2017. All parties were represented by counsel. Having considered the case file, trial testimony, exhibits, arguments of counsel, post-trial filings, and applicable law, the court renders the following findings of fact and conclusions of law.[5]

I. THE ACT

*3 The Act defines a dismemberment abortion as:

> dismember[ing] the living unborn child and extract[ing] the unborn child one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or a similar instrument that, through the convergence of two rigid levers, slices, crushes, or grasps, or performs any combination of those actions on, a piece of the unborn child's body to cut or rip the piece from the body. The term does not include an abortion that uses suction to dismember the body of an unborn child by sucking pieces of the unborn child into a collection container. The term includes a dismemberment abortion that is used to cause the death of an unborn child and in which suction is subsequently used to extract pieces of the unborn child after the unborn child's death.

Ch. 441, § 6 (to be codified at Tex. Health & Safety Code § 171.151). The Act further provides:

> Dismemberment Abortions Prohibited.
>
> (a) A person may not intentionally perform a dismemberment abortion unless the dismemberment abortion is necessary in a medical emergency.

> (b) A woman on whom a dismemberment abortion is performed, an employee or agent acting under the direction of a physician who performs a dismemberment abortion, or a person who fills a prescription or provides equipment used in a dismemberment abortion does not violate Subsection (a).

Id. (to be codified at Tex. Health & Safety Code § 171.152). A "medical emergency," is defined as:

> a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Texas Health & Safety Code Ann. § 171.002(3) (West 2017). A physician found to be in violation of the Act commits a state-jail-felony criminal offense punishable by a minimum of 180 days to a maximum of two years in jail and a fine of up to $10,000. Ch. 441, § 6 (to be codified at Tex. Health & Safety Code § 171.153); Tex. Penal Code Ann. § 12.35(a), (b) (West Supp. 2016).

Thus, the Act includes civil and criminal penalties for those who perform a dismemberment abortion. "Dismemberment abortion" is not a medical term used by physicians nor have the parties directed the court to any medical reference using the term. Although the Act does not specifically state, the parties do not dispute that the Act prohibits the performance of an outpatient standard D & E abortion unless fetal demise occurs *in utero* before the fetus is removed from the woman. It is also undisputed that after approximately 15 weeks of pregnancy and before a fetus is viable, nationwide the most common second-trimester abortion is a standard D & E without inducing *in utero* fetal demise. [6]

II. REVIEW OF ABORTION REGULATIONS

*4 **[1]** **[2]** This case is not the first attempt by a state to regulate second-trimester abortions. The court thus begins its analysis by reviewing existing law. Three basic principles arising from *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992), guide this court. First, before fetal viability it is the right of a woman,

> to obtain an abortion without undue interference from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure. Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health. And third, the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.

Gonzales v. Carhart, 550 U.S. 124, 145, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007); *see also Stenberg v. Carhart*, 530 U.S. 914, 921, 120 S.Ct. 2597, 147 L.Ed.2d 743 (2000).

[3] **[4]** **[5]** Before viability, a state "may not prohibit any woman from making the ultimate decision to terminate her pregnancy." *Gonzales*, 550 U.S. at 146, 127 S.Ct. 1610 (quoting *Casey*, 505 U.S. at 879, 112 S.Ct. 2791); *see also Stenberg*, 530 U.S. at 921, 120 S.Ct. 2597. Also, a state "may not impose upon this right an undue burden, which exists if a regulation's 'purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.' " *Id.* On the other hand, "regulations which do no more than create a structural mechanism by which the State ... may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose." *Id.* (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791).

[6] In *Whole Woman's Health v. Hellerstedt*, the Court reiterated the undue-burden standard: "a statute which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." —— U.S. ——, 136 S.Ct.

2292, 2309, 195 L.Ed.2d 665 (2016) (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791). "The rule announced in *Casey*, [ ] requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S.Ct. at 2309. "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877, 112 S.Ct. 2791. Whether an obstacle is substantial—and a burden is therefore undue—must be judged in relation to the benefits that the law provides. *Whole Woman's Health*, 136 S.Ct. at 2309. Where a law's burdens exceed its benefits, those burdens are by definition undue, and the obstacles they embody are by definition substantial. *Id.* at 2300, 2309–10, 2312, 2318. In the bitter debate surrounding whether society should sanction any abortion, "substantial" is often called upon to carry a greater weight than contextual analysis justifies. The court construes "substantial" to mean no more and no less than "of substance."

*5 This court, in conducting an undue-burden analysis, must "consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2309. The court must "weigh[ ] the asserted benefits against the burdens." *Id.* at 2310. Said another way, the court must answer the question, "does the benefit bring with it an obstacle of substance?"

III. THE SUPREME COURT HAS PREVIOUSLY ADDRESSED SECOND-TRIMESTER ABORTIONS

On two occasions the Supreme Court has reviewed state laws challenged on the basis that, by their effect, the laws (1) banned the previability standard D & E procedure and (2) the ban was an undue burden on women's right to choose an abortion. *See Gonzales*, 550 U.S. at 132, 127 S.Ct. 1610; *Stenberg*, 530 U.S. at 920, 120 S.Ct. 2597. In each instance, the Court determined that to the extent a law directly reached or might be interpreted in such a way to reach the previability standard D & E procedure performed before fetal demise, the law imposed an undue burden on a woman seeking a pre-fetal-viability abortion. *Gonzales*, 550 U.S. at 164–65, 127 S.Ct. 1610; *Stenberg*, 530 U.S. at 939, 120 S.Ct. 2597. In each case, the Court determined that, although a law that by its effect bans partial-birth abortions and is appropriately narrow may stand, a broadly written law with the effect of also banning previability standard D & E abortions cannot withstand the undue-burden test. *Stenberg*, 530 U.S. at 939–40, 120 S.Ct. 2597.

Gonzales addresses a federal law that punishes one who knowingly performs a partial-birth abortion. There the Court reviewed the previability standard D & E procedure, observing the following,

> Some doctors, especially later in the second trimester, may kill the fetus a day or two before performing the surgical evacuation. They inject digoxin or potassium chloride into the fetus, the umbilical cord, or the amniotic fluid. Fetal demise may cause contractions and make greater dilation possible. Once dead, moreover, the fetus' body will soften, and its removal will be easier. Other doctors refrain from injecting chemical agents, believing it adds risk with little or no medical benefit.

Id. at 136, 127 S.Ct. 1610.

Gonzales holds that because the law the Court was reviewing "allows, among other means, a commonly used and generally accepted method,[ ] it does not construct a substantial obstacle to the abortion right." 550 U.S. at 165, 127 S.Ct. 1610. "The conclusion that the [law] does not impose an undue burden is supported by other considerations. Alternatives are available to the prohibited procedure. As we have noted, the [law] does not proscribe [the standard] D & E." *Id.* at 164, 127 S.Ct. 1610. The law's "prohibition only applies to the delivery of 'a living fetus.' " *Id.* Drafting the law so narrowly "allows, among other means, a commonly used and generally accepted method, so it does not construct a substantial obstacle to the abortion right." *Id.* at 165, 127 S.Ct. 1610. The "other means" and "generally accepted method" referred to in *Gonzales* is the standard D & E procedure performed before fetal demise. Further, the Court in *Gonzales* found that the law in question, "excludes most [standard] D & Es in which the fetus is removed in pieces, not intact. If a doctor intends to remove the fetus in parts from the outset, the doctor will not have the requisite

intent to incur criminal liability." 550 U.S. at 151, 127 S.Ct. 1610.

Previously, the Court held in *Stenberg* that a broadly drawn state law that in addition to banning the D & X procedure by its effect also banned the standard D & E procedure. The Court held that because the law under review was not narrowly tailored to include only the D & X procedure, the law imposed an undue burden upon a woman's right to choose a previability abortion. *Stenberg*, 530 U.S. at 945–46, 120 S.Ct. 2597.

> *6 In sum, using this law some present prosecutors and future Attorneys General may choose to pursue physicians who use [the standard] D & E procedures, the most commonly used method for performing previability second trimester abortions. All those who perform abortion procedures using that method must fear prosecution, conviction, and imprisonment. The result is an undue burden upon a woman's right to make an abortion decision. We must consequently find the statute unconstitutional.

Id.

[7] [8] This court need look no further. Although narrowly drawn, the Act has the undisputed effect of banning the standard D & E procedure when performed before fetal demise. Presented with the Supreme Court's determinations in *Stenberg* and *Gonzalez*–that laws with the effect of banning the standard D & E procedure result in an undue burden upon a woman's right to have an abortion and are therefore unconstitutional–the court concludes, based on existing precedent alone, the Act must fail. Once the Supreme Court has defined the boundaries of a constitutional right, a district court may not redefine those boundaries. [7] Further the role of the district court is to preserve a right, not to search for a way to evade or lessen the right.

IV. CURRENT FETAL–DEMISE LITIGATION

At least seven states other than Texas have enacted fetal-demise laws similar to the Act. In some of those states, similar challenges to that here have been raised. [8]

A federal district court in Alabama rendered a permanent injunction enjoining Alabama from enforcing a similar fetal-demise law. *See West Ala. Women's Ctr. v. Miller*, No. 2:15–CV–497–MHT, — F.Supp.3d ——, 2017 WL 4843230 (M.D. Ala. Oct. 26, 2017). The court concluded that the law imposed an undue burden on women seeking previability abortions at the only two clinics in Alabama that provide abortions beginning at 15 weeks. The court concluded that the Alabama law would unquestionably prevent women in Alabama from obtaining a previability abortion after 15 weeks. The court determined that there was no question that the fetal-demise law is unconstitutional as applied to the plaintiffs. *Id.*

In Arkansas, a federal district court rendered a preliminary injunction after concluding that should an Arkansas fetal-demise law be allowed to become effective, the fraction of women for whom the law is relevant would immediately lose the right to obtain a previability abortion anywhere in the state after 14 weeks. *Hopkins v. Jegley*, No. 4:17–CV–00404–KGB — F.Supp.3d ——, 2017 WL 3220445 (E.D. Ark. July 28, 2017), *appeal docketed*, No. 17–2879 (8th Cir. Aug. 28, 2017).

The Kansas Court of Appeals, by an equally divided court, affirmed a district court's grant of a temporary injunction that enjoined a similar fetal-demise law. *Hodes & Nauser MDs, P.A. v. Schmidt*, 52 Kan.App.2d 274, 368 P.3d 667 (Kan. Ct. App. 2016) (en banc). The plaintiffs alleged that the law violated the Kansas Constitution's right to an abortion. "Given the additional risk, inconvenience, discomfort, and potential pain associated with these alternatives [digoxin or potassium-chloride injections or umbilical-cord transection], some of which are virtually untested, we conclude that banning the standard D & E, a safe method used in about 95% of second-trimester abortions, is an undue burden on the right to abortion." *Id.* at 678.

*7 In Oklahoma, a state district court granted a temporary injunction preventing a similar fetal-demise law from taking effect. *Nova Health Sys. v. Pruitt*, No. CJ–2015–1838, slip op., 2015 WL 10319422 (Okla. Cty. Dist. Ct. Oct. 28, 2015). Applying federal law, the court recognized the determinations made in *Gonzales* and

Stenberg and that the Supreme Court had previously balanced the same competing interests. The court ruled, *inter alia*, that the plaintiffs had demonstrated a likelihood of success on the merits that the law was likely to be found unconstitutional. *Id.*

In Louisiana, a similar suit has been filed. *June Med. Servs. LLC v. Gee*, No. 3:16–CV–0444–BAJ (M.D. La. July 1, 2016).

The court finds persuasive the reasoning expressed by these courts regarding similar laws requiring fetal demise before a physician may perform a standard D & E abortion.

V. THE INTEREST OF THE STATE OF TEXAS

[9] No legislative findings accompany the Act. Therefore, this court does not have an explanation from the Texas Legislature of its purpose in enacting the law. Generally, a state bears the burden of demonstrating a link between the legislation enacted and what it contends are the state's interests. *See Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 430, 103 S.Ct. 2481, 76 L.Ed.2d 687 (1983), *overruled on other grounds, Casey*, 505 U.S. at 833, 112 S.Ct. 2791 (describing state's burden). The State here argues that the Act advances respect for the dignity of the life of the unborn and protects the integrity of the medical profession. The court assumes without deciding the legitimacy of these interests. *See Whole Woman's Health*, 136 S.Ct. at 2310 (assuming state had legitimate interests despite law's lack of legislative findings).

VI. BURDEN ON WOMEN

Plaintiffs claim that the Act forces a Texas woman who is between 15 and 20 weeks pregnant and seeking a previability abortion to wait an additional 24 hours, make an additional trip to the provider for a fetal-demise procedure, sustain an additional invasive, medically unnecessary procedure, and be subjected to heightened health risks.[9] Further, Plaintiffs claim physicians will stop performing standard D & E abortions altogether due to ethical and legal concerns, thereby rendering abortions essentially unavailable to a Texas woman who is 15 weeks pregnant.

The State responds that the Act does not render second-trimester abortions unavailable, because fetal demise can be safely achieved with one of three procedures before a physician performs a standard D & E: (1) use of a hypodermic needle to inject the drug digoxin transabdominally or vaginally; (2) an injection of potassium chloride directly into the fetal heart; and (3) umbilical-cord transection. By causing fetal demise before performing the evacuation portion of the standard D & E, a physician does not violate the Act. The State argues that the Act, therefore, neither bans the standard D & E procedure nor places an undue burden on a woman's right to choose a second-trimester abortion.

As with the State's interest in passing the Act, there are no legislative findings that these fetal-demise procedures are safe and effective or that any is necessary for the preservation of the life or health of the woman. The court, based on the judicial record, will make its own findings in that regard. *See Whole Woman's Health*, 136 S.Ct. at 2310 ("[T]he relevant statute here does not set forth any legislative findings. Rather, one is left to infer that the legislature sought to further a constitutionally acceptable objective. For a district court to give significant weight to evidence in the judicial record in these circumstances is consistent with this Court's case law.")

VII. BENEFITS AND BURDENS

Second-trimester abortions

***8** Considering the fact that [second-trimester partial-birth and standard D & E abortion] procedures seek to terminate a potential human life, our discussion may seem clinically cold or callous to some, perhaps horrifying to others. There is no alternative way, however, to acquaint the reader with the technical distinctions among different abortion methods and related factual matters, upon which the outcome of this case depends.

Stenberg, 530 U.S. at 923, 120 S.Ct. 2597. The Court then describes in great detail the methods of performing an abortion. *See id.* at 923–29, 120 S.Ct. 2597; *Gonzales*, 550 U.S. at 135–37, 127 S.Ct. 1610. The description in *Stenberg*, is consistent with the evidence presented to this court in every material respect. The standard D & E procedure has not materially changed in medical practice since physicians across the country began performing the procedure in the 1970s. An abortion always results in the death of the fetus. The extraction of the fetus from the womb occurs in every abortion. Dismemberment of the fetus is the inevitable result. The

evidence before the court is graphic and distasteful. But this evidence is germane only to the State's interest in the dignity of fetal life and is weighed on the State's side of the scale. It does not remove weight from the woman's side. And it does not add weight to tip the balance in the State's favor.

At 15 weeks and sometimes sooner, physicians perform surgical abortions and most often perform a standard D & E procedure. The physician dilates the woman's cervix and may use a combination of suction and forceps or other instruments to remove the fetus and other *in utero* tissue through the dilated cervical opening. At 15 weeks, because the fetus is larger than the dilated cervical opening, separation or disarticulation of fetal tissue usually occurs, as the physician will use instruments in addition to suction to move fetal tissue through the cervix. [10] The evacuation phase takes approximately 10 minutes. The standard D & E procedure is safely performed as a one-day outpatient procedure and is the most common abortion procedure available after 15 weeks of pregnancy.

Other than a standard D & E, the only abortion procedure available to physicians during the second trimester is induction abortion, by which the physician uses medication to induce labor and delivery of a nonviable fetus. Induction of labor is uncommon both in Texas and nationally. Induction abortions must be performed in a hospital or similar facility that has the capacity to monitor a patient overnight. Induction abortions can last from five hours to three days; are extremely expensive; entail more pain, discomfort, and recovery time for the patient than a standard D & E procedure; and are medically contraindicated for some patients.

There is no dispute that the Act does not apply to a standard D & E procedure during which the physician—through a separate procedure—causes fetal demise before beginning the evacuation phase of the abortion. Although procedures that cause fetal demise before evacuation exist—(1) use of a hypodermic needle to inject digoxin; (2) an injection of potassium chloride directly into the fetal heart; and (3) an umbilical-cord transection–Plaintiffs contend none is safe, adequately studied, or medically appropriate. Plaintiffs contend that physicians attempting any of these other procedures before evacuation, would impose risks with no medical benefit to the patient, each of these procedures is untested, has unknown risks, and is of uncertain efficacy. Requiring fetal demise in every instance before starting evacuation would mandate that physicians experiment on their patients, and many or even most physicians would decline to do so.

*9 The State responds that physicians, especially later in the second trimester, are able to cause fetal demise by injecting digoxin or potassium chloride into the fetus a day or two before performing the evacuation portion of the D & E procedure. Thus, far from imposing a ban on the standard D & E procedure, the State argues the Act does not prevent doctors from performing a second-trimester abortion.

The Act criminalizes the performance of a standard D & E abortion unless fetal demise occurs before the evacuation. Accordingly, the State contends that the court's determination whether the law imposes a substantial obstacle to abortion access turns on the feasibility of the State's proposed fetal-demise methods. Although the court will consider the argument, the State's reliance on adding an additional step to an otherwise safe and commonly used procedure in and of itself leads the court to the conclusion that the State has erected an undue burden on a woman's right to terminate her pregnancy prior to fetal viability. After considering all of the medical expert testimony, the court concludes that pre-evacuation fetal demise provides no additional medical benefit to a woman undergoing a standard D & E abortion.

Again, as there are no legislative findings that any method to cause *in utero* fetal demise is safe and effective, the court proceeds to make its own findings based on the judicial record. *See Whole Woman's Health*, 136 S.Ct. at 2310.

Fetal demise by digoxin injection

To inject digoxin, physicians begin by using an ultrasound machine to visualize the woman's uterus and the fetus. The physician then inserts a long surgical needle—approximately four inches in length—through the patient's skin, abdomen, and uterine muscle, in order to inject the drug into the fetus. Digoxin works slowly. Physicians generally allow 24 hours after the injection before attempting the evacuation phase of a standard D & E. If the attempt to inject into the fetus fails, the physician may inject digoxin into the amniotic fluid, but evidence suggests that method is less effective in causing fetal demise. Digoxin injections are painful and invasive because they are administered through a transabdominal needle without anesthesia. This may be somewhat

alleviated by injecting digoxin transvaginally, preceded by pain-relieving injections and moderate sedation.

When injected into the fetus or amniotic fluid, digoxin has a failure rate ranging between 5% and 10%. A variety of factors, such as uterine positioning, fetal positioning, and the presence of uterine fibroids, can affect whether the physician is actually able to inject digoxin into the fetus or the amniotic fluid successfully. First, fetal and uterine positioning can affect whether the physician is able to reach the fetus or the amniotic fluid with a needle. Additionally, uterine fibroids, which are benign tumors on the uterine walls affecting over half of women, may impede the needle, because they may be calcified and impenetrable. These factors can make it difficult or impossible for the needle to reach the fetus or the amniotic fluid. The court finds that digoxin injections are not always reliable for inducing fetal demise.

The majority of studies on digoxin injection focus on pregnancies at or after 18 weeks. Only a few studies have included cases at 17 weeks, and no study has been presented to the court on the efficacy, dosage, or safety of injecting digoxin into women before 17 weeks of pregnancy. Requiring digoxin injection before 18 weeks of pregnancy, therefore, would require a woman be subjected to an arguably experimental procedure without any counterbalancing benefits.

*10 Additionally, the testimony of all opining experts reveals that digoxin injections are associated with heightened risk of extramural delivery—the unexpected and spontaneous expulsion of the fetus from the uterus while the woman is outside a clinical setting and without medical help—as well as heightened risk of infection and subsequent hospitalization, compared to the standard D & E procedure. A study showed that a digoxin injection is six times more likely to result in hospitalization compared to injection of a placebo; the injection carries an increased risk of infection; and it is twice as likely than amniocentesis to result in extramural delivery. Additionally, an extramural delivery of the fetus can cause bleeding and require medical attention, aside from being very upsetting to the woman. The court finds that even when administered successfully after 18 weeks, digoxin injections carry significant health risks.

A woman undergoing a digoxin injection would be required to make an additional trip to the clinic 24 hours before her appointment for the standard D & E procedure. In Texas, a woman seeking an abortion must, on the first visit to an abortion clinic, receive an ultrasound and state-mandated counseling. *See* Tex. Health & Safety Code Ann. §§ 171.011–.012 (West 2017). The woman must then wait at least 24 hours before making a second visit. If seeking a second-trimester abortion, the woman would then receive the digoxin injection. Finally, on a third visit, which the court finds would almost invariably occur the next day, the woman would undergo the standard D & E abortion procedure.

Based on the unreliability of the procedure, unknown risks for women before 18 weeks of pregnancy, the potential need to inject a second dose of digoxin, increased risk of complications, increased travel burden, and the pain and invasiveness of the procedure, the court finds that digoxin injection is not a feasible method of, in all instances, inducing fetal demise before performing the evacuation phase of a standard D & E abortion. The court concludes, however, that in all instances the procedure would create a substantial obstacle to woman's right to an abortion.

Fetal demise by potassium-chloride injection

Potassium chloride will also cause fetal demise if injected directly into the fetal heart. Physicians administer potassium-chloride injections by using an ultrasound machine as a guide for viewing and inserting a long surgical needle through a woman's abdomen, and uterine muscle, and then into the fetal heart, which is very small; at 15 weeks of pregnancy, the fetal heart is about the size of a dime. Usually potassium-chloride injections are performed in a hospital, not a clinic. Upon administering potassium chloride, the fetal heart stops almost immediately. As with digoxin, potassium-chloride injections are invasive and painful, because they are administered through a transabdominal surgical-needle injection without anesthesia.

Injecting potassium chloride requires great technical skill and is extremely challenging. The procedure requires extensive training generally available only to subspecialists in high-risk obstetrics, referred to as maternal-fetal medicine. The record evidence is, and there is no credible dispute, that the procedure of injecting potassium chloride is very rare, as it carries much more severe risks for a woman, including death if the physician places the solution in the wrong place.

Physicians at Texas abortion clinics who are not trained in maternal-fetal medicine, would have to receive training to induce fetal demise through injection of potassium chloride. This particular training is not taught to obstetrics and gynecology residents or to family-planning fellows, whose training involves abortion care, because the procedure is generally only used for high-risk, multi-fetal pregnancy reductions.[11] Indeed the only subspecialists who are trained to perform potassium-chloride injections are maternal-fetal medicine fellows, who go through three years of highly supervised training to specialize in high-risk pregnancies. The court finds it would be virtually impossible for all physicians at abortion clinics to receive the specialized training necessary in order for this procedure to be a meaningfully available fetal-demise method in Texas.

*11 Additionally, potassium-chloride injections carry serious risks to the patient. Because potassium chloride has harmful effects on the heart, inadvertently injecting it into the woman's circulation can endanger the woman. Injections of potassium chloride may also increase the risk of uterine perforation and infection, due to the inherent risks associated with transabdominal injections. Given all of this, the risk associated with a potassium-chloride injection before the evacuation phase of the standard D & E abortion is not quantifiable because there has been no study on the efficacy or safety of the injection when administered in this manner.

Finally, as with digoxin, fetal and uterine positioning, and the presence of uterine fibroids may complicate or even prevent the administration of potassium-chloride injections in many women. And as with a digoxin, a potassium-chloride injection is unnecessary and a potentially harmful medical procedure with no counterbalancing medical benefit for the woman.

The court finds that potassium-chloride injections are not a feasible method of inducing fetal demise before a physician conducts the evacuation phase of a standard D & E procedure. The procedure is technically challenging and has serious health risks. Additionally, there is no practical way for Plaintiffs to receive adequate training so that they may perform potassium-chloride injections safely. The court finds potassium-chloride injection to be an unavailable method for physicians attempting to induce fetal demise before performing the evacuation phase of a standard D & E abortion in Texas. To the extent the procedure could or would be used, the court concludes that, like a digoxin injection, the procedure would create a substantial obstacle to woman's right to an abortion.

Fetal demise by umbilical-cord transection

To perform umbilical-cord transection, the physician dilates the woman's cervix enough to allow the passage of instruments to transect the cord. Once the cervix is dilated, the physician uses ultrasound to visualize the umbilical cord. Using the ultrasound for guidance, the physician then punctures the amniotic membrane, inserts an instrument into the uterus, grasps the cord, and with another instrument cuts the cord. The physician must then wait for the fetal heart activity to cease, which usually occurs within 10 minutes, after which the physician could perform the evacuation phase of the standard D & E procedure.

The success and ease of umbilical-cord transection depends on the placement of the umbilical cord. If the umbilical cord is blocked by the fetus, it could be very difficult and very risky to attempt to grasp the cord. Also, other factors make cord transection technically difficult: (1) lack of visualization; (2) continuous shrinking of the uterus; and (3) the size of the umbilical cord.

Although the physician can easily view the fetus and the umbilical cord by ultrasound before the amniotic membrane is punctured, once punctured, the amniotic sac drains from the uterus, which makes it more difficult to view the location of the umbilical cord. As the fluid drains, the uterus contracts, pushing the contents of the uterus against each other. Thus, the physician must identify, reach, and transect the cord with a surgical instrument without good visualization aid or space between different types of tissues. Depending on a woman's week of pregnancy, the cord may be very thin; at 15 weeks, the cord is the width of a piece of yarn.

Cord transection carries significant health risks to the patient, including blood loss, infection, and injury to the uterus. Unlike a physician practicing in a hospital, a clinic physician does not have access to blood services for patients at risk of serious blood loss, nor does the physician have access to subspecialists such as anesthesiologists.

*12 Umbilical-cord transection is not a feasible method for fetal demise as it is essentially an experimental

procedure that carries no medical benefits to the woman. The State argues that umbilical-cord transection is a safe method for fetal demise before the evacuation phase of the standard D & E based on one study, which is the only existing study that has examined umbilical-cord transection as a method for fetal demise before the evacuation phase of the standard D & E procedure.

The technical difficulties of performing umbilical-cord transection, the potential for serious harm, the lack of sufficient research on risks associated with the procedure, and the unavailability of training, indicate to the court that requiring umbilical-cord transection as a method of fetal demise *in utero* would impose a substantial obstacle to a woman's right to terminate a pregnancy before viability of a fetus.

VIII. BALANCING BURDENS AND BENEFITS

[10] To prevail, a plaintiff alleging a facial challenge to an abortion regulation must demonstrate that "in a large fraction of cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791. In the large-fraction test, the court uses as the denominator those cases "in which the provision at issue is relevant," which is a narrower class than "pregnant women" or "the class of women seeking abortions." *Whole Woman's Health*, 136 S.Ct. at 2320 (citing *Casey*, 505 U.S. at 894–95, 112 S.Ct. 2791). As the Act affects every second trimester D & E abortion procedure in Texas, the class of women here consists of all women in Texas who are 15 to 20 weeks pregnant and seek an outpatient second-trimester D & E abortion.

The State argues that the Act is an appropriate use of its state regulatory power to bar certain medical procedures and substitute others, all in furtherance of its legitimate interest in regulating the medical profession in order to promote respect for the unborn life. The State maintains that its interests are sufficiently strong to justify the burdens the Act imposes on a woman seeking a second-trimester abortion because, even under the Act, the pregnant woman retains the ability to terminate the pregnancy at or after 14 weeks.

The State's argument is premised on it being feasible for all Texas abortion providers to utilize one of the three fetal-demise methods. The court finds that none of the proposed fetal-demise methods is feasible for any physician other than a specialist in maternal-fetal medicine, without substantial additional training, to induce fetal demise *in utero* in all instances before performing the evacuation phase of a standard D & E procedure. Three abortion providers testified that they would stop performing second-trimester abortions if required to always ensure *in utero* fetal demise before performing the evacuation phase of a standard D & E abortion. It is unknown how many other abortion providers would choose to not undergo the additional training and cease performing abortions.

Ensuring fetal demise before evacuation is a significant change in the way a standard D & E abortion has been historically performed. Although the State presented some evidence to the contrary, the evidence substantially supports that a careful physician will not proceed with the D & E procedure until 24 hours after injecting digoxin to cause fetal demise. The delay is to be certain that fetal demise has occurred before evacuation. Standing alone, this additional delay constitutes an undue burden, but that burden is increased by Texas law requiring a 24–hour delay in the abortion process after the woman undergoes a sonogram and is counseled. If the Act alone does not create an undue burden, its interaction with other Texas law pushes the previability-abortion burden on a woman seeking a second-trimester abortion above the undue threshold.

***13** The court finds that under the Act, all women seeking a second-trimester abortion at 15 weeks would have to endure a medically unnecessary and invasive procedure that increases the duration of what otherwise is a one-day standard D & E procedure. The Act further subjects those women to additional risks of complications. The court finds that these women would be in a unique position: the court is unaware of any other medical context that requires a doctor-in contravention of the doctor's medical judgment and the best interest of the patient-to conduct a medical procedure that delivers no benefit to the woman. For most women, the Act increases the length of the procedure from one day to two, not including the mandatory first visit for a sonogram and counseling, before attempting fetal demise, thereby increasing all accompanying costs of perhaps travel, lodging, time away from work, and child care. This delay and extra cost would be particularly burdensome for low-income women, many of whom must wait to seek a second-trimester abortion,

because of the time required to obtain the funding to cover the costs of the abortion.

The court concludes that requiring a woman to undergo an unwanted, risky, invasive, and experimental procedure in exchange for exercising her right to choose an abortion, substantially burdens that right. The court concludes that the Act fails to "confer[ ] benefits sufficient to justify the burdens upon access [to abortion] that [the Act] imposes." *Whole Woman's Health*, 136 S.Ct. at 2299. Indeed, the court finds the Act's burdens, by definition, exceed its benefits, those burdens are undue, and the obstacles they embody are, by definition, substantial. *Id.* at 2300, 2309–10, 2312, 2318. Additionally, the court concludes that whether the court weighs the asserted state interests against the effects of the provisions or examines only the effects of the provisions, Plaintiffs have carried their burden of demonstrating that the Act creates an undue burden for a large fraction of women for whom the Act is a substantial rather than an irrelevant restriction. The record includes sufficient evidence from Plaintiffs of causation that the Act's requirements will lead to this effect. *See id.* at 2313. The court concludes the Act is an inappropriate use of the State's regulatory power over the medical profession to bar certain medical procedures and substitute others in furtherance of the State's legitimate interest in regulating the medical profession in order to promote respect for the life of the unborn. The State's valid interest in promoting respect for the life of the unborn, although legitimate, is not sufficient to justify such a substantial obstacle to the constitutionally protected right of a woman to terminate a pregnancy before fetal viability.

IX. CONCLUSION

In resolving the issues presented by this case, the court has been guided by existing Supreme Court precedent and influenced by the contemporaneously developing opinions of the several courts who have considered legislation similar to the Act. Words are important. That a woman may make the decision to have an abortion before a fetus may survive outside her womb is solely and exclusively the woman's decision. The power to make this decision is her right. The State's legitimate concern with the preservation of the life of the fetus is an interest having its primary application once the fetus is capable of living outside the womb. The court must weigh the right against the interest. The State's position is that the right and the interest are entitled to equal weight. But this is incorrect. That the right is dominant over the interest is self-evident. The right is absolute and the interest is given only marginal consideration before fetal viability. The Act dictates fetal demise at a time before fetal viability. The Act establishes a point of fetal demise before fetal viability. In so doing, the Act does not further the health of the woman before the fetus is viable.

It is the nature of parties to a dispute to examine precedent and select language that appears to support an individual party's position in the dispute. It is the function of the court to examine the language on which each party relies to support its position. The court must determine the overall effect of the precedent where, as here, the parties direct the court to the same precedent. The court must be mindful not to allow discrete statements in a precedential court's opinion to consume the holding of the precedent. This court concludes that *Stenberg* and *Gonzales* lead inescapably to the conclusion that the State's legitimate interest in fetal life does not allow the imposition of an additional medical procedure on the standard D & E abortion—a procedure not driven by medical necessity. Here the State's interest must give way to the woman's right. The Act does more than create a structural mechanism by which the State expresses profound respect for the unborn. The Act intervenes in the medical process of abortion prior to viability in an unduly burdensome manner.

***14** The court concludes that the determinations in *Stenberg* and *Gonzales* that the standard D & E abortion procedure, unencumbered by any requirement of *in utero* fetal demise before a physician performs the evacuation phase of the abortion, is a safe alternative abortion procedure to the banned D & X or partial-birth abortion procedure. The court further concludes that although the Act advances a valid state interest, the Act "has the effect of placing a substantial obstacle in the path of a woman's choice, [and therefore] cannot be considered a permissible means of serving its legitimate ends." *Casey*, 505 U.S. at 877, 112 S.Ct. 2791. The court concludes that the Act is facially unconstitutional. Accordingly, the court will declare the Act void and permanently enjoin Defendants from enforcing the Act.

All Citations

--- F.Supp.3d ----, 2017 WL 5641585

Footnotes

1 Plaintiffs Whole Woman's Health, Planned Parenthood Center for Choice, Planned Parenthood of Greater Texas Surgical Health Services, Planned Parenthood South Texas Surgical Center, Alamo City Surgery Center PLLC, Southwestern Women's Surgery Center, Nova Health Systems, Inc., Robin Wallace, M.D., Bhavik Kumar, M.D., M.P.H., and Alan Braid, M.D., bring this action on behalf of themselves their staff, physicians, and patients (collectively "Plaintiffs").

2 The Act was effective September 1, 2017. *Id.* at ch. 441, § 22. The court temporarily enjoined enforcement of the Act. *See infra* pp. 3–4.

3 The court refers to the abortion procedure at issue as a "standard D & E" procedure to distinguish it from an "intact D & E," also known as a "D & X" procedure, which involves dilating the cervix enough to remove the fetus intact. The intact D & E or D & X procedure is banned under the Federal Partial–Birth Abortion Ban Act of 2003, unless fetal demise is induced before the procedure. *See* 18 U.S.C. § 1531; *Gonzales v. Carhart*, 550 U.S. 124, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007) (upholding federal partial-birth abortion ban).

A second-trimester partial-birth abortion occurs when a physician causes fetal demise after delivering vaginally an intact living fetus to an anatomical landmark. *Gonzales*, 550 U.S. at 147–48, 127 S.Ct. 1610. A fetus's anatomical landmarks are, in the case of a head-first presentation, the entire fetal head outside the woman's body or, in the case of breech presentation, any part of the fetal trunk past the navel outside the woman's body. *Id.*

Texas recently banned partial-birth abortions and that law is not at issue in this case. *See* Act of May 26, 2017, 85th Leg., R.S., ch. 441, § 6, 2017 Tex. Sess. Law Serv. 1166–67 (West) (to be codified at Tex. Health & Safety Code Ch. 171, Subchapter F, §§ 171.101–.106).

4 Plaintiffs and five of the eight local-prosecutor defendants, including Defendants Bexar County Criminal District Attorney Nicholas LaHood, El Paso District Attorney Jaime Esparza, Harris County Criminal District Attorney Kim Ogg, Hidalgo County Criminal District Attorney Ricardo Rodriguez, Jr., and Travis County District Attorney Margaret Moore ("Nonparticipating Defendants") stipulated to the following: (1) the Nonparticipating Defendants will not (a) enforce the challenged portions of the Act until a final non-appealable decision has been rendered in this action; (b) participate in litigating this action unless required to do so thereby conserving prosecutorial resources; and (c) will not file answers, unless ordered by the court; and (2) Plaintiffs (a) will take no default judgment against the Nonparticipating Defendants; and (b) will not seek attorney's fees, penalties, damages, or any costs or expense of any kind from the Nonparticipating Defendants.

Defendants Dallas County District Attorney Faith Johnson, McLennan County Criminal District Attorney Abelino Reyna, and Tarrant County Criminal District Attorney Sharen Wilson are actively participating in this action. As the interests of these three local-prosecutor defendants are aligned with Paxton, the court refers to them collectively as "the State."

5 In making these findings and conclusions, the court has considered the record as a whole. The court has observed the demeanor of the witnesses and has carefully weighed that demeanor and the witnesses' credibility in determining the facts of this case and drawing conclusions from those facts. Further, the court has thoroughly considered the testimony of both sides' expert witnesses and has given appropriate weight to their testimony in selecting which opinions to credit and upon which not to rely. *See Garcia v. Kerry*, 557 Fed.Appx. 304, 309 (5th Cir. 2014) ("It is settled law that the weight to be accorded expert opinion evidence is solely within the discretion of the judge sitting without a jury. In a bench trial, the district court is not obligated to accept or credit expert witness testimony.") (citing *Pittman v. Gilmore*, 556 F.2d 1259, 1261 (5th Cir. 1977); *Albany Ins. Co. v. Anh Thi Kieu*, 927 F.2d 882, 894 (5th Cir. 1991)). The court concludes that all witnesses who testified as an expert were qualified to do so. Courts are not well equipped to weigh competing medical testimony from equally qualified witnesses. The court, however, has carefully considered the testimony, compared each expert witness' testimony with that of the others, and makes these findings on what the court concludes is the greater weight of the credible evidence. All findings of fact contained herein that are more appropriately considered conclusions of law are to be so deemed. Likewise, any conclusion of law more appropriately considered a finding of fact shall be so deemed.

6 The duration of a woman's pregnancy is commonly referred to by trimesters. The first trimester runs from the first through twelfth week and the second trimester runs from the thirteenth through twenty-sixth week. *See Stenberg v. Carhart*, 530 U.S. 914, 923–25, 120 S.Ct. 2597, 147 L.Ed.2d 743 (2000). The third trimester begins the twenty-seventh week and continues through the end of the pregnancy. Medical literature refers to the gestational age of a fetus as the number of weeks after a woman's last menstrual period—"LMP"—followed after a decimal point by the number of days of the subsequent week. For example, "16.0 LMP" represents a gestational age of 16 weeks, 0 days, while "17.6 weeks LMP" represents a gestational age of 17 weeks, 6 days. The court will refer to only complete weeks and absent the LMP designation.

7 The federal courts spread across the country owe respect to each other's efforts and should strive to avoid conflicts, but each has an obligation to engage independently in reasoned analysis. Binding precedent for all is set only by the Supreme Court, and for the district courts within a circuit, only by the court of appeals for that circuit.
In re Korean Air Lines Disaster of Sept. 1, 1983, 829 F.2d 1171, 1176 (D.C. Cir. 1987) (Ginsberg, J.).

8 There have been no legal challenges raised to the fetal-demise laws in Mississippi and West Virginia.

9 In Texas, it is only in extraordinary circumstances that an abortion may be performed after 20 weeks. *See* Tex. Health & Safety Code Ann. §§ 171.044, .046 (West 2017).

10 Generally, before 15 weeks physicians do not use the standard D & E procedure because the fetus and all other *in utero* materials will pass through a dilated cervix using only suction.

11 A multi-fetal pregnancy reduction is a procedure during which one or more of the fetuses in the same pregnancy are terminated and the rest are carried to full term.

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2017 WL 4843230
Only the Westlaw citation is currently available.
United States District Court, M.D. Alabama, Northern Division.

WEST ALABAMA WOMEN'S CENTER, et al., on behalf of themselves and their patients, Plaintiffs,

v.

Dr. Thomas M. MILLER, in his official capacity as State Health Officer, et al., Defendants.

CIVIL ACTION NO. 2:15cv497–MHT (WO)

Signed 10/26/2017

Synopsis

Background: Providers of abortion and other reproductive-health services in Alabama brought action, on their own behalf and on behalf of patients, against State Health Officer, State Attorney General, and district attorneys, alleging two Alabama statutes regulating abortions and abortion clinics violated the Due Process Clause of the Fourteenth Amendment. Following preliminary injunction enjoining enforcement of statutes, 217 F.Supp.3d 1313, plaintiffs moved to permanently enjoin enforcement.

Holdings: The District Court, Myron H. Thompson, J., held that:

[1] school-proximity law was likely to provide little to no benefit to State's asserted interests in minimizing disruption and supporting a parent's right to control their children's exposure to subject of abortion;

[2] school-proximity law would likely result in substantial, or even insurmountable, burdens on Alabama women attempting to obtain pre-viability abortions;

[3] school-proximity law constituted undue burden on abortion access in violation of Due Process; and

[4] law imposing criminal penalty on physicians who purposely perform "dismemberment abortions" constituted an undue burden on abortion access in violation of Due Process.

Motion granted.

West Codenotes

Held Unconstitutional
Ala. Code §§ 22-21-35(b), 26-23G-1

Attorneys and Law Firms

Alexa Kolbi–Molinas, Andrew Beck, Jennifer Lee, Pro Hac Vice, American Civil Liberties Union, New York, NY, Randall C. Marshall, ACLU of Alabama Foundation, Inc., Montgomery, AL, for Plaintiffs.

Bethany Lynn Bolger, Carol Robin Gerard, Phillip Brian Hale, Alabama Department of Public Health, Office of General Counsel, William G. Parker, Jr., Office of the Governor Alabama State Capitol, Andrew L Brasher, Office of the Attorney General, James William Davis State of Alabama, Office of the Attorney General Montgomery, AL, for Defendants.

OPINION

Myron H. Thompson, UNITED STATES DISTRICT JUDGE

***1** In *West Alabama Women's Center v. Miller*, 217 F.Supp.3d 1313 (M.D. Ala. 2016) (Thompson, J.), this court preliminarily enjoined enforcement of two Alabama statutes, enacted on May 12, 2016, that regulate abortions and abortion clinics. The court must now address whether the two laws should be permanently enjoined. Based on the following findings of fact and conclusions of law, this court holds that they should be. While the court parrots many of its earlier findings and conclusions, it substantially and importantly expands on some as well.

I. INTRODUCTION

The first challenged statute, the "school-proximity law," provides that the Alabama Department of Public Health may not issue or renew licenses to abortion clinics located within 2,000 feet of a K–8 public school. *See* 1975 Ala.

Code § 22–21–35. The second statute, the "fetal-demise law," effectively criminalizes the most common method of second-trimester abortion—the dilation and evacuation, or D & E, procedure—unless the physician induces fetal demise before performing the procedure. *See* 1975 Ala. Code § 26–23G–1 et seq.

The plaintiffs are West Alabama Women's Center (a reproductive-health clinic in Tuscaloosa, Alabama) and its medical director and Alabama Women's Center (a reproductive-health clinic in Huntsville, Alabama) and its medical director. The plaintiffs sue on behalf of themselves and their patients. The defendants are the State Health Officer, the State Attorney General, and the district attorneys for Tuscaloosa and Madison Counties, where the clinics are located. All defendants are sued in their official capacities.

The plaintiffs claim that the school-proximity and fetal-demise laws unconstitutionally restrict abortion access in Alabama in violation of the Due Process Clause of the Fourteenth Amendment. Jurisdiction is proper under 28 U.S.C. §§ 1331 (federal question) and 1343 (civil rights).

Based on the record (including evidence presented at a hearing), the court holds both laws unconstitutional. The evidence compellingly demonstrates that the school-proximity law would force the closure of two of Alabama's five abortion clinics, which together perform 72 % of all abortions in the State. Meanwhile, the fetal-demise law would prohibit the most common method of second-trimester abortions in Alabama, effectively terminating the right to an abortion in Alabama at 15 weeks. Because these laws clearly impose an impermissible undue burden on a woman's ability to choose an abortion, they cannot stand.

II. HISTORICAL BACKGROUND

Previously, this court described in some detail a "climate of hostility," both non-violent and violent, surrounding the provision of legal abortions in Alabama. *Planned Parenthood Se., Inc. v. Strange*, 33 F.Supp.3d 1330, 1334 (M.D. Ala. 2014) (Thompson, J.). Doctors trained in and willing to provide abortion care in Alabama are rare, and face retaliation and harassment on a daily basis as a result of their work. For example, protesters have repeated gathered outside one of the plaintiff physician's private medical practice and the clinic carrying signs calling her "a murderer". Robinson White Decl. (doc. no. 54–4) ¶¶ 8–10. A group also launched a public campaign to convince a hospital to revoke her admitting privileges; this effort included protests in front of the hospital, televised press conferences, and leafletting cars and stores near the hospital. *Id.* at ¶ 9. Providers of abortion services face difficulties recruiting, hiring, and retaining staff willing to provide abortion care in the face of this stigma and constant uncertainty as to the clinics' continued existence. Women seeking abortion services in Alabama suffer distinct threats to their privacy: anti-abortion protesters regularly protest outside of clinics and harass patients as they exit and enter; at times, protesters have brought cameras and posted photos of clinic patients and their license plates online. Second Gray Decl. (doc. no. 54–1) ¶ 28. "As of 2001, there were 12 clinics providing abortions in the State. Today, that number has dwindled to five." *Planned Parenthood Se., Inc. v. Strange*, 33 F.Supp.3d 1330, 1334 (M.D. Ala. 2014) (Thompson, J.).

***2** In addition, against this historical backdrop and as outlined in the court's preliminary-injunction opinion, *W. Ala. Women's Ctr.*, 217 F.Supp.3d at 1319, abortion clinics and their physicians have been subject to a number of regulations in Alabama. In just the last six years, Alabama has passed a host of legislation to regulate how and where abortion care can be provided. The court, however, now mentions only some of those laws.

In 2011, the State prohibited abortions at 20 or more weeks after fertilization—that is, 22 weeks after the last menstrual period [1]—unless a woman's condition necessitates an abortion to avert her death or "serious risk of substantial and irreversible physical impairment of a major bodily function." 1975 Ala. Code § 26–23B–5.

In 2013, the State enacted a law requiring all abortion clinics to meet the same building safety codes applicable to ambulatory surgical centers. 1975 Ala. Code § 26–23E–9. Under that requirement, abortion clinics must meet the standards of the "NFPA 101 Life Safety Code 2000 edition," *id.*, which include requirements for egress, fire protection, sprinkler systems, alarms, emergency lighting, smoke barriers, and special hazard protection. To comply with that law, abortion clinics in Alabama conducted extensive renovations or had to purchase new spaces and relocate.

That same year, the State required all physicians who perform abortions in the State to hold staff privileges at a hospital within the same statistical metropolitan area as the clinic. *See* 1975 Ala. Code § 26–23E–4(c). This court held the staff-privileges requirement to be unconstitutional. *See Planned Parenthood Se., Inc. v. Strange*, 33 F.Supp.3d 1330 (M.D. Ala. 2014) (Thompson, J.); *see also Planned Parenthood Se., Inc. v. Strange*, 172 F.Supp.3d 1275 (M.D. Ala. 2016) (Thompson, J.) (determining appropriate relief).

In 2014, the State extended from 24 to 48 hours the time physicians must wait between providing informed consent explanations to patients and conducting the abortion procedure. *See* 1975 Ala. Code § 26–23A–4.

Also in 2014, Alabama enacted a law modifying the procedures for minors seeking to obtain an abortion. At the time, minors who were unable or unwilling to obtain written consent from their parent or guardian could instead seek judicial approval from a juvenile judge or county court. The new law authorized presiding judges to appoint a guardian ad litem to represent "the interests of the unborn child," and required that the county district attorney be notified and joined as a party. 1975 Ala. Code § 26–21–4(i)-(j). These provisions were declared unconstitutional. *See Reprod. Health Servs. v. Marshall*, —— F.Supp.3d ——, No. 2:14-CV-1014-SRW, 2017 WL 3223916 (M.D. Ala. July 28, 2017) (Walker, M.J.).

In 2016, on the same day, Alabama enacted the two statutes now challenged in this litigation: the school-proximity law and the fetal-demise law.

This year, the Alabama legislature passed a proposed constitutional amendment that declares the State's public policy is "to recognize and support the sanctity of unborn life and the rights of unborn children, including the right to life," and "to ensure the protection of the rights of the unborn child in all manners and measures lawful and appropriate." 2017 Ala. Laws Act 2017–188 (H.B. 98). Alabamians will vote on the amendment in November 2018.

*3 The vast majority of abortions performed in Alabama occur in the remaining five outpatient clinics.[2] The plaintiffs operate two of the clinics: the Alabama Women's Center, located in Huntsville, and the West Alabama Women's Center, in Tuscaloosa.[3] Together, these two clinics provided 72 % of all abortions in Alabama in 2014. Second Johnson Decl. Ex. D (doc. no. 54–2) at 35.

The Alabama Women's Center, which opened in 2001, is the only abortion clinic in Huntsville, in the far northern part of the State. The Huntsville metropolitan area, with a population of 417,593, is Alabama's second largest urban area.[4] In addition to abortion services, the Huntsville clinic provides contraceptive counseling and care, testing and treatment for sexually transmitted infections, pap smears, pregnancy testing, and referrals for prenatal care and adoption. In 2014, approximately 14 % of the abortions in Alabama took place at the Huntsville clinic. Second Johnson Decl. Ex. D (doc. no. 54–2) at 35.

The West Alabama Women's Center began operations in 1993 and is the only abortion clinic in Tuscaloosa and all of west Alabama. The Tuscaloosa metropolitan area is Alabama's fifth largest urban area. The Tuscaloosa clinic provides reproductive health services to women, including abortions, birth control, treatment for sexually transmitted infections, pregnancy counseling, and referrals for prenatal care and adoption. In 2014, approximately 58 % of the abortions in Alabama took place at the Tuscaloosa clinic, far more than at any other clinic. Second Johnson Decl. Ex. D (doc. no. 54–2) at 35.

The Tuscaloosa and Huntsville clinics are the only clinics in Alabama that perform abortions at or after 15 weeks of pregnancy. Prior to 15 weeks, most abortions are performed either through the use of medication or the dilation and curettage method, the latter of which uses suction to empty the contents of the uterus. Because, starting at 15 weeks, it ordinarily is not possible to complete an abortion using suction alone, patients must go to clinics that offer D & E. The D & E procedure is a surgical abortion method where a physician uses instruments and suction to remove the fetus and other contents of the uterus. In 2014, the Huntsville and Tuscaloosa clinics provided about 496 abortions starting at 15 weeks, all of which were D & E abortions. AWC Summary of Abortions Performed, Pls.' Ex. 17; WAWC Summary of Abortions Performed, Pls.' Ex. 16. That said, the vast majority of abortions performed by the Huntsville and Tuscaloosa clinics occur prior to 15 weeks and therefore do not involve D & E.

III. LITIGATION BACKGROUND

The court will not go into the history of this litigation, which was outlined in the preliminary-injunction opinion, *see W. Ala. Women's Ctr.*, 217 F.Supp.3d at 1320–21, other than to add that, after the preliminary injunction was issued, the parties asked the court to enter a final judgment based on the existing record without conducting any further discovery or evidentiary proceedings. The court granted the parties' joint motion to do so, and now makes its final findings of fact and enters its final conclusions of law.

IV. LEGAL STANDARDS

*4 [1] In its most recent discussion of a woman's right to an abortion, the Supreme Court opened its opinion with this succinct statement: "[A] statute which, while furthering a valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Whole Woman's Health v. Hellerstedt*, —— U.S. ——, 136 S.Ct. 2292, 2309, 195 L.Ed.2d 665 (2016) (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)).

[2] Women have a substantive due-process right to terminate a pregnancy before the fetus is viable. To determine whether that right has been violated, the governing standard is "undue burden." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 876–79, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992) (plurality opinion).[5] In *Casey*, a plurality of the Court concluded that, if a government regulation has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus," the regulation is an undue burden on a woman's right to have an abortion and is unconstitutional. *Id.* at 877, 112 S.Ct. 2791. *Casey* recognized that a woman's right of privacy extends to freedom "from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Id.* at 896, 112 S.Ct. 2791 (majority opinion) (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972)).

[3] "[T]he heart of this test is the relationship between the severity of the obstacle and the weight of the justification the State must offer to warrant that obstacle.... [T]he more severe the obstacle a regulation creates, the more robust the government's justification must be, both in terms of how much benefit the regulation provides towards achieving the State's interests and in terms of how realistic it is the regulation will actually achieve that benefit." *Planned Parenthood Se., Inc. v. Strange*, 9 F.Supp.3d 1272, 1287 (M.D. Ala. 2014) (Thompson, J.); *see also Whole Woman's Health*, 136 S.Ct. at 2309 (the undue-burden analysis requires a court to "consider the burdens a law imposes on abortion access together with the benefits those laws confer"); *Planned Parenthood of Wis. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) (Posner, J.) ("The feebler the [state interest], the likelier the burden, even if slight, [is] to be 'undue' in the sense of disproportionate or gratuitous.").

[4] The undue-burden test requires courts to examine "the [challenged] regulation in its real-world context." *Planned Parenthood Se., Inc. v. Strange*, 9 F.Supp.3d 1272, 1287 (M.D. Ala. 2014) (Thompson, J.); *Casey*, 505 U.S. at 888–98, 112 S.Ct. 2791 (majority opinion) (examining the effects of the spousal notification provision on women in abusive relationships). In *Whole Woman's Health*, the Supreme Court endorsed the district court's consideration of the actual impact of the challenged laws on the Texas abortion clinics and their patients. *Whole Woman's Health*, 136 S.Ct. at 2312. In concluding that the law imposed an undue burden, the district court, and then the Supreme Court, considered several facts, including that half of Texas clinics closed after enforcement of the law commenced; that clinicians from the El Paso clinic would be unable to gain admitting privileges at hospitals, because not once did they transfer an abortion patient to a hospital; and that the closures resulted in an almost 30-fold increase in the number of women of reproductive age more than 200 miles from a clinic. *Id.* at 2312–13.

*5 Courts must consider the burdens imposed by the new law or regulation against the backdrop of existing laws and regulations on abortion in the jurisdiction as well as others enacted at the same time. As Judge Posner explained, "[w]hen one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered." *Planned Parenthood v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013), *cert. denied*, —— U.S. ——, 134 S.Ct. 2841, 189 L.Ed.2d 807 (2014); *accord*

Planned Parenthood Arizona, Inc. v. Humble, 753 F.3d 905, 915 (9th Cir. 2014) (Fletcher, J.) (describing relevant factors to burdens analysis as including "the ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations"), *cert. denied*, —— U.S. ——, 135 S.Ct. 870, 190 L.Ed.2d 702 (2014).

[5] States may have myriad interests in regulating abortion. These interests may come in all shapes and forms, from protecting fetal life or maternal health to regulating the medical profession. Nevertheless, the State's interests—however legitimate—cannot "place[ ] a substantial obstacle in the path of a woman's choice [to have a pre-viability abortion]." *Whole Woman's Health*, 136 S.Ct. at 2309 (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)). And a State's interests surely cannot swallow the right. *See Casey*, 505 U.S. at 846, 112 S.Ct. 2791 (reaffirming the essential holding of *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) that "[b]efore viability, the State's interests are not strong enough to support ... the imposition of a substantial obstacle to the woman's effective right to elect the procedure"). The court will now apply the undue-burden test to the facts of this case.

V. THE SCHOOL–PROXIMITY LAW

[6] The school-proximity law provides that the Alabama Department of Public Health "may not issue or renew a health center license to an abortion clinic or reproductive health center that performs abortions and is located within 2,000 feet of a K–8 public school." 1975 Ala. Code § 22–21–35(b). The parties agree that both the Tuscaloosa and Huntsville clinics are located within 2,000 feet of at least one K–8 public school. Order on Pretrial Hearing (doc. no. 93), Stip. 3(b) at 13. Each clinic is licensed by the Department; if the school-proximity law were to take effect, the parties agree the Department could not renew either clinic's license to continue operations at its existing location.

Because no legislative findings accompany the school-proximity law, the court is without an explanation from the legislature of the purpose for the law. The plaintiffs have submitted newspaper articles, to which the State has not objected, that report that Reverend James Henderson, a leader of anti-abortion protesters outside the Huntsville clinic, drafted the bill that ultimately became the school-proximity law, with the purpose of shutting down the Huntsville clinic. Newspaper Article, Second Johnson Decl. Ex. H (doc. no. 54–2) at 56. Another article reported that Governor Robert Bentley's staff offered Henderson assistance in seeking sponsors for the bill. *Id.* Ex. I at 61.

The State has asserted that the purpose of the school-proximity law was to further two interests: minimizing disturbance in the educational environment and supporting a parent's right to control his or her children's exposure to the subject of abortion.

With regard to these interests, the State acknowledges two things. First, the State's interests are threatened by demonstrations outside the clinics, but not by the clinics themselves. Tr. of Final Pre–Trial Status Conf. (doc. no. 99) at 35:1–11. Thus, the school-proximity law attempts to serve the State's interests through an expressed *means* (the 2000–foot prohibition on clinics) to an unexpressed *end* (the relocation of the demonstrations away from public K–8 schools). Second, the State does not contend, and the court finds no evidence, that the demonstrators had any effect on the educational environment *inside* any school; the State concedes that its only concern is disruption *outside* of schools due to the presence of protesters near the clinics. *Id.* at 37:9–21.

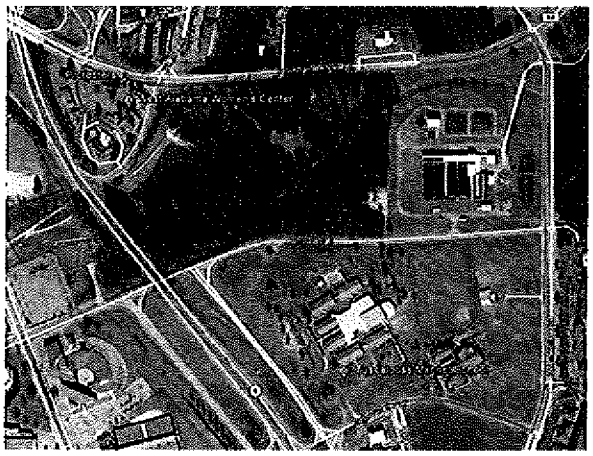
***6** In the absence of legislative findings, the court will now, as discussed below, make findings based on the "judicial record" as to the State's two asserted interests. *Whole Woman's Health*, 136 S.Ct. at 2310 ("[T]he relevant statute here does not set forth any legislative findings. Rather, one is left to infer that the legislature sought to further a constitutionally acceptable objective.... For a district court to give significant weight to evidence in the judicial record in these circumstances is consistent with this Court's case law.").

The court is persuaded that the school-proximity law would impose a substantial obstacle on a woman's right to obtain a pre-viability abortion. As discussed below, the evidence presented to the court reflects that the State's asserted interests are only minimally, if at all, furthered by the law, while the burden imposed on a woman's right to obtain an abortion is substantial.

A. State's Interests

The State's interests are furthered by neither the law's means (the 2000–foot prohibition on clinics) nor its end (the relocation of the demonstrations).

In Tuscaloosa, a middle school sits just within 2,000 feet of the clinic, but a vast wooded area separates the school and the clinic. Map, Second Gray Decl. Ex. E (doc. no. 54–1) at 77 (showing Tuscaloosa clinic at 1,986 feet away from middle school); Pl. Ex. 27 (satellite view showing wooded area separating clinic and school); Tr. Vol. II (doc. no. 111) at 106:4–9. Up to five protesters (but usually fewer than that) stand outside the clinic on weekdays, but they are neither visible nor audible to children entering, exiting, or inside the school. Second Gray Decl. (doc. no. 54–1) at ¶ 35; Tr. Vol. II (doc. no. 111) at 104:15–20, 108:24–25—109:1–5. Indeed, this court has been presented with no evidence that the children (or parents) at the Tuscaloosa school are even aware that an abortion clinic is located nearby. [6] Because the record does not reflect that any K–8 public school children within 2,000 feet of the Tuscaloosa clinic are even aware of the clinic or the demonstrations at the clinic, the school-proximity law does not serve either of the State's asserted purposes of minimizing disruption or supporting a parent's right to control his or her children's exposure to the subject of abortion.



The State does not dispute that, while the law impacts the Tuscaloosa clinic, it was targeted to the "perceived problem" at the Huntsville clinic. Tr. Vol. III (doc. no. 112) at 14:12–16.

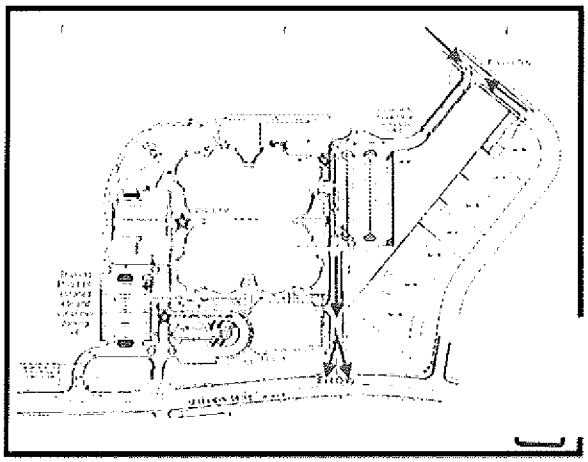
In Huntsville, two to 15 protesters stand outside the clinic on weekdays. Tr. Vol. I (doc. no. 110) at 168:5–12 (medical director of Huntsville clinic estimates two to five protesters on a regular basis and up to 10 protesters on weekdays); Second Johnson Decl. (doc. no. 54–2) ¶ 31 (owner of Huntsville clinic estimates five to 15 protesters). Occasionally larger crowds of protesters congregate on weekends, when school is not in session. Tr. Vol. I (doc. no. 110) at 169:5–10; Johnson Dep., Def. Ex. 20 (doc. no. 81–20) at 3:13–18 (describing large rallies with up to 150 protesters). Demonstrators may yell at patients as they enter or exit the clinic. Tr. Vol. I (doc. no. 110) at 216:9–11.

Two public schools that include some or all of grades K–8—Highlands Elementary School and the Academy for Academics and Arts—are located within 2,000 feet of the Huntsville clinic.

*7 The respective entrances to Highlands and the clinic are on different streets, and they are approximately three blocks apart. *Id.* at 176:18–19, 177:5–6. It is not necessary to drive past the clinic to access the school. *Id.* at 176:20–23. The record contains absolutely no evidence of concerns expressed by the school's students or their parents about the Huntsville clinic or the demonstrations near it. Thus, as to Highlands, the court finds the State's two interests (minimizing disruption and supporting a parent's right to control their children's exposure to the subject of abortion) would not in any way be furthered by the closing or relocation of the Huntsville clinic.

The Academy for Academics and Arts sits diagonally across a five-lane street from, and to the east of, the Huntsville clinic. Published newspaper articles report that some parents have complained about the presence of

protesters near the clinic.[7] But the record reflects no disturbance to the educational environment: no evidence suggests that protests are visible or audible from inside the school; no evidence suggests the classroom setting has been in any way disturbed by the protests; and no evidence suggests that children are hindered or disturbed while entering or exiting the school. In fact, although demonstrators sometimes stand across the street from the Huntsville clinic and close to an Academy driveway, that driveway is not the school's primary driveway and is not typically used by parents who are dropping off or picking up children. Instead, it is used by parents and others to access an attached parking lot if they need to enter the school for business or opt to walk their child into the school, and even then no evidence suggests that children have been hindered or disturbed in those instances. Tr. Vol. II (doc. no. 111) at 26:21–25—27:1–3. The entrance used by parents during normal drop-off and pick-up is accessed from another street on the opposite side of the school, and the driveway used by buses bringing children to and from the school is on the same street as the clinic but further up the road. *Id.* at 27:21–25—28:1–8; Tr. Vol. I (doc. no. 110) at 174:16–23; Pl. Ex. 33 (depicting traffic flow at the Academy). Because there is no evidence of disruption to the school's educational environment, the court finds the State's interest in limiting disruption in the educational environment would not be measurably advanced by the closing or relocation of the Huntsville clinic.



Also as to the Academy, the State's interest in supporting a parent's right to control his or her children's exposure to the subject of abortion would be only weakly furthered by the closing or relocation of the Huntsville clinic. The State failed to present evidence of a significant problem: the record contains one report of one mother who had to respond to questions from her son, an Academy student, about the subject of abortion after he witnessed a protest. Newspaper Article, Def. Ex. 16 (doc. no. 81–16).

In addition, the State's statutory means (the closing or relocation of the Huntsville clinic) will not lead to the State's intended end (the relocation of demonstrations away from the Academy). The evidence reflects, and the court so finds, that protests will continue at the Huntsville clinic's current location even if the school-proximity law were to take effect. Anti-abortion protesters have demonstrated not just outside the Huntsville clinic, but also outside the private practice of the clinic's medical director, Dr. Yashica Robinson White, as well as a hospital where she holds admitting privileges. Robinson White Decl. (doc. no. 54–4) ¶¶ 8–10; Tr. Vol. I (doc. no. 110) at 179:2–16; 180:14–20. Because Robinson White previously used the Huntsville clinic's current site for her private obstetrics and gynecology practice, and two and as many as 10 protesters routinely demonstrated outside the facility on weekdays, protests occurred at the site even before it became an abortion clinic. Robinson White Decl. (doc. no. 54–4) ¶ 10; Tr. Vol. I (doc. no. 110) at 166:22–25—167:1–5. Robinson White credibly testified that, if the law were to go into effect and the clinic were to close, she would again use the facility for her private practice, which would likely engender protests again. Tr. Vol. I (doc. no. 110) at 181:22–25—182:1–12; Robinson White Decl. (doc. no. 54–4) ¶ 16. Moreover, Robinson White testified that, if the clinic closed, she would perform abortions at the facility[8] through her private practice, all but guaranteeing continued protests at the site, irrespective of the passage of the law. *Id.* As a result, the law will not stop protests at the site.

*8 Based on the judicial record, the court therefore finds that the school-proximity law would provide little to no benefit to the State's asserted interests in minimizing disruption and supporting a parent's right to control his or her children's exposure to the subject of abortion.[9]

B. Burdens Imposed on Women

[7] In addition to examining the State's asserted interests, the court must also "consider the burdens [the] law imposes on abortion access." *Whole Woman's Health*, 136 S.Ct. at 2309.

The parties do not dispute that, if the school-proximity law goes into effect, the State Health Department could not renew the licenses of the Huntsville and Tuscaloosa abortion clinics at their existing locations. After the expiration of their existing licenses, the clinics would need to relocate or shut down. The court finds, based on the judicial record, that the Tuscaloosa clinic and the Huntsville clinic would not be able to relocate and that, as a result, the two clinics would have to shut down if the law were to take effect. Tr. Vol. I (doc. no. 110) at 164:19–25—165:1–18; Second Gray Decl. (doc. no. 54–1) ¶ 34; Second Johnson Decl. (doc. no. 54–2) ¶ 3.

The evidence credibly shows that, because each clinic incurred significant expenses as a result of the surgical-center requirement imposed on abortion providers by the State in 2013, neither clinic would be financially able to relocate now. Because the Huntsville clinic was not able to bring its old building into compliance with the surgical-center standards, it was forced to relocate to a new facility (the place where Robinson White had leased space for her private practice), which cost $ 530,000 to purchase and more than $ 100,000 for building renovations. Tr. Vol. I (doc. no. 110) at 160:23–24, 162:1–4. To cover those expenses, Dalton Johnson, the clinic owner, and Robinson White, the medical director and sole physician, incurred significant personal financial debt. Second Johnson Decl. (doc. no. 54–2) ¶ 16 ("In order to purchase the facility, I cashed in all of my retirement savings; borrowed from my life insurance policy; refinanced the mortgage on the Madison Street building and pulled all the equity out of it; took out a $ 100,000 line of credit; and spent money I had inherited from my father, who had recently passed away. In addition, Dr. Robinson White and I each maxed out every one of our credit cards."); Tr. Vol. I (doc. no. 110) at 162:11–18 (Robinson White explaining that the clinic owner removed "all of the equity" from his mortgage on the prior clinic facility; and that she and the clinic owner "emptied" their savings accounts, "took all of the cash value" out of their insurance policies, obtained a line of credit through a bank, and "maxed out" all of their credit cards). Johnson remains hundreds of thousands of dollars in debt from these expenses. Second Johnson Decl. (doc. no. 54–2) ¶ 17 (describing outstanding debt on $ 100,000 line of credit; $ 90,000 owed to life insurance policy; and hundreds of thousands of dollars remaining on mortgages for both prior and current clinic facilities). The testimony of Robinson White, which the court found highly credible, establishes that she and Johnson have sacrificed significant personal financial resources to continue operating the Huntsville clinic.

*9 The Tuscaloosa clinic spent $ 130,000 to renovate its existing facility to comply with the surgical-center requirements. Second Gray Decl. (doc. no. 54–1) ¶ 32. Purchasing a new facility now would require the Tuscaloosa clinic's owner to use retirement funds or go into debt, which she would not be able to pay off at this stage of her career. *Id.* ¶ 34.

The Tuscaloosa and Huntsville clinics could not rely on leasing a new facility. Anti-abortion protesters in Alabama have targeted the landlords that lease space to organizations and individuals that provide abortions. After demonstrations targeted the former landlord of the Tuscaloosa clinic, the landlord did not renew the clinic's lease. *Id.* ¶ 31. Similarly, during an earlier search for a Huntsville facility, Johnson hired real estate agents and engaged in an extensive six-month search, but "each and every time [h]e would meet with the owner or real estate agent of a building [h]e wanted to lease, the moment [h]e informed prospective lessors that [h]e intended to operate an abortion clinic in the space, they would not lease to [him]." Johnson Decl. (doc. no. 54–2) ¶¶ 12, 14. Robinson White explained that, during the Huntsville clinic's recent relocation, the stigma surrounding abortion made it difficult to find a banker and closing attorney to work with them. Tr. Vol. I. (doc. no. 110) at 165:2–11. These difficulties are consistent with the court's previous finding that abortion providers in Alabama face a "climate of extreme hostility to the practice of abortion." *Planned Parenthood Se.*, 33 F.Supp.3d at 1334. Against this backdrop, the plaintiffs have credibly demonstrated that they would not be able to relocate; the clinics would finally be forced to close.

The State contends that the burdens analysis should not consider the probable closure of the Huntsville and Tuscaloosa clinics because whether the clinics close depends on "the idiosyncrasies of [the clinics'] specific financial position." Def. Br. (doc. no. 81) at 9. In other words, the State seems to argue that the court should not consider the actual financial circumstances of the clinics in assessing whether the law would impose an undue burden Alabama women's right to choose an abortion. This contention misapprehends the undue-burden case law.

As this court has previously explained, the undue-burden analysis requires an examination of the "real-world context" of the challenged statute and its actual effects—and not just those circumstances that are directly attributable to the statute. *Planned Parenthood Se.*, 9 F.Supp.3d at 1285–87. In *Casey*, the Supreme Court's evaluation of the burdens imposed by a spousal-notification law took into consideration the reality that many women live in abusive relationships, and that requiring notification to an abusive spouse could impose a potentially insurmountable barrier to obtaining an abortion for those women. *See Casey*, 505 U.S. at 888–898, 112 S.Ct. 2791 (majority opinion). Contrary to the State's reasoning, it was not relevant to the Court's analysis that the spousal-notification law did not cause the women to live in abusive relationships, or that the idiosyncrasies of different relationships would result in varying impacts on different women. The Court carefully considered the real-world context in which the law would play out, and, based on that context, determined that the notification requirement would have imposed a substantial obstacle to access to abortion.

***10** Moreover, "[w]hen one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered." *Van Hollen*, 738 F.3d at 796 (Posner, J.). Here, the financial peril of the remaining clinics is a direct result of earlier legislation regulating abortion in the State. The court cannot ignore, and in fact must take into consideration, the financial pressures on the plaintiff clinics resulting from those laws in assessing whether the school-proximity law imposes an undue burden.

Similarly, courts have repeatedly recognized that legislation that imposes substantial costs on abortion providers places burdens on women's access to abortion because the costs discourage other clinics from opening or filling the gaps caused by closures. In *Whole Woman's Health*, the Supreme Court observed that the costs of $ 1 to $ 3 million required to achieve compliance with Texas's surgical-center requirement were "considerable." 136 S.Ct. at 2318. Evidence of those costs, the Court reasoned, "supports the conclusion that more surgical centers will not soon fill the gap when licensed facilities are forced to close." *Id.*; *see also Casey*, 505 U.S. at 901, 112 S.Ct. 2791 (plurality opinion) (finding that recordkeeping requirements, which "[a]t most ... increase the cost of some abortions by a slight amount" do not impose an undue burden, but acknowledging that "at some point increased cost could become a substantial obstacle"); *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 542 (9th Cir. 2004) (concluding that application of new licensing and regulatory scheme to abortion facilities, which would have required abortion providers to expend "[t]ens of thousands of dollars," contributed to undue-burden finding).

Because new abortion clinics are very unlikely to sprout up to fill the gaps, the closure of two of Alabama's five abortion clinics would leave only three abortion clinics operating in the State—one each in Birmingham, Montgomery and Mobile—while the rest of Alabama, including the highly populated metropolitan areas of Huntsville and Tuscaloosa, would have no licensed abortion providers at all. The resulting burdens on women would be substantial. [10]

First, women would lose the right to obtain an abortion in Alabama altogether when they reached 15 weeks of pregnancy, because the Tuscaloosa and Huntsville clinics are the only providers of abortions beginning at 15 weeks of pregnancy. [11]

***11** Second, while abortions before 15 weeks would remain available in Alabama, women who would currently rely on the Huntsville or Tuscaloosa clinics would need to travel significantly greater distances. This burden would become particularly devastating for low-income women who represent the majority of women seeking abortions in Alabama. Katz Decl. (doc. no. 54–11) ¶ 15; *see also* Second Henshaw Decl. (doc. no. 54–3) ¶ 9 (half of all abortion recipients in the United States have incomes below the federal poverty level). In particular, 82 % of the Tuscaloosa clinic patients live at or below 110 % of the federal poverty level. Gray Decl. (doc. no. 54–1) ¶ 45. In Huntsville, over 60 % of the clinic's patients receive financial assistance from the government. Tr. Vol. I (doc. no. 110) at 206:18–23. If the Huntsville clinic closed, a woman in Huntsville would need to travel at least 200 miles round-trip to Birmingham for the next-closest abortion provider. Without a clinic in Tuscaloosa, a woman there would need to travel at least 110 miles round-trip to Birmingham. Multiple studies have concluded that longer travel distances to access an abortion provider correlate with fewer women obtaining abortions. Second Henshaw Decl. (doc. no. 54–3) ¶¶ 4–8, 19. The court has previously discussed the serious impact of the "first 50

miles" of travel on women seeking abortions, and that "when a clinic closes, the largest effects are actually felt by women who, prior to the closure, needed to travel only short distances, less than 50 miles." *Planned Parenthood Se.*, 33 F.Supp.3d at 1358–60. The Supreme Court has also recognized that longer travel distances, when taken together with other burdens, increase the burdens on women seeking an abortion. *Whole Woman's Health*, 136 S.Ct. at 2313 (citing evidence that, after regulation took effect, the number of women living more than 150 and 200 miles from an abortion provider skyrocketed). Here, without the school-proximity law, women in Huntsville and Tuscaloosa could obtain an abortion with a short trip within the city. If the law were to take effect, women in those cities would be required to arrange lengthy out-of-town trips, including obtaining access to transportation, time off from work, childcare, and lodging. Alabama law already requires women to make two trips to the clinic: one to satisfy the informed consent requirement, and one—at least 48 hours later—for the procedure.[12] But not all women have the means to do so, which would either prevent such women from obtaining an abortion altogether or delay their ability to obtain one. Second Henshaw Decl. (doc. no. 54–3) ¶¶ 14, 24 (noting that half of women who experience unwanted delay in obtaining abortions attributed the delay to arrangements such as raising funds, transportation, locating an abortion provider, and organizing childcare).

The increased difficulty of accessing an abortion clinic would be compounded by the three remaining abortion clinics' lack of sufficient capacity to meet the new demand. As a result, not all women who would choose to have an abortion could obtain one. The Huntsville and Tuscaloosa clinics have performed the majority of abortions in Alabama in recent years: combined, they performed 72 % of all abortions in Alabama in 2014, 60 % of all abortions in 2013, and 55 % of all abortions in 2012. Second Johnson Decl. Ex. D (doc. no. 54–2) at 35–37. Together, the Huntsville and Tuscaloosa clinics performed 5,833 abortions in 2014, compared to 2,218 abortions provided by the three remaining clinics combined. *Id.* at 35. The three remaining clinics could not shoulder the plaintiff clinics' caseload.

As the directors of Alabama's three other clinics explained, if the Huntsville and Tuscaloosa clinics were to close, they project that they could at most reach a combined maximum capacity of 4,500 procedures per year (including the 2,218 they already provide), but this increase in capacity would depend on a significant expansion in staffing and services, which is unlikely in light of the climate surrounding abortion in Alabama. Ayers Decl. (doc. no. 54–7) ¶¶ 8–10; Fox Decl. (doc. no. 54–8) ¶¶ 4–5. For example, the Montgomery clinic performed fewer than 900 abortions in 2014; stretched its resources to perform 1,200 abortions because of the temporary closure of the Tuscaloosa clinic in 2015; and estimates that it could perform a maximum of 1,800 abortions per year at the outermost limit—an estimate dependent on recruiting additional physicians and support staff that it has previously struggled to hire because of the stigma surrounding abortion in Alabama. Ayers Decl. (doc. no. 54–7) ¶¶ 6–8. The Mobile and Birmingham clinics, which provided a combined total of 1,342 abortions in 2014, estimate that, with an expansion of capacity to provide abortions four days per month, they could perform 2,700 abortions per year—but they too are currently struggling to expand capacity because of staffing troubles. Fox Decl. (doc. no. 54–8) ¶ 5; Donald Decl. Ex. F, Induced Terminations of Pregnancy 2014 Report (doc. no. 81–14) at 19. Notably, none of the remaining clinics have plans to expand their services to provide abortions at or after 15 weeks, so women seeking abortions in that timeframe would simply be out of luck.

*12 Also, capacity constraints, especially when combined with the increased travel times, would introduce delays in women obtaining abortions. Later-term abortions, if delayed past the 14th week of the pregnancy, carry greater medical risks and also increase the cost of the procedure; if the delay extends to the 22nd week of pregnancy, it would become illegal for a woman to obtain an abortion in Alabama, with certain exceptions for the life and health of the mother. 1975 Ala. Code § 26–23B–5.

For women in abusive relationships, delays could make the difference between obtaining or not obtaining an abortion at all: where a battered woman attempts to conceal her pregnancy from her abuser, she needs to be able to obtain an abortion before she starts to show; for a woman needing to pass her abortion off to an abusive partner as a miscarriage, she needs to receive a medication abortion (because it looks exactly like a miscarriage), which is only available until 10 weeks of pregnancy. In both scenarios, the longer the delay, the more likely the woman will not be able to get an abortion in time to

conceal it from her abuser. To impose additional delay by requiring women to travel further will result in some women taking an unwanted pregnancy to term. Walker Decl. (doc. no. 54–9) ¶¶ 15–16.

Furthermore, the abortions that the remaining clinics could provide likely would not be equal in quality to the care provided prior to the law taking effect: in the crowded clinics that would surely result, women are "less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered." *Whole Woman's Health*, 136 S.Ct. at 2318. To assume otherwise flies in the face of "common sense," which "suggests that, more often than not, a physical facility that satisfies a certain physical demand will not be able to meet five times that demand without expanding or otherwise incurring significant costs." *Id.* at 2317. These factors, too, would impose a burden on women seeking an abortion.

Each of these factors—the unavailability of abortions beginning at 15 weeks, the increased travel times, and the reduced capacity, increased wait times, and potentially reduced quality of care at Alabama's three remaining clinics—would result in women facing significantly increased, and even insurmountable, barriers to obtaining an abortion.

Where these types of barriers exist, it is likely that some women will pursue risky alternatives. *Cf. Whole Woman's Health*, 136 S.Ct. at 2321 (Ginsburg, J., concurring) ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux*, [13] at great risk to their health and safety."); *Planned Parenthood Se.*, 33 F.Supp.3d at 1362–63 (describing greater risk that women would attempt to obtain an abortion illegally where travel-related obstacles and capacity constraints are imposed). The Tuscaloosa clinic has had firsthand experience with attempts to self-abort, including when the clinic was temporarily closed in 2015. During that time, women would nonetheless come to the clinic seeking an abortion—including one woman who threatened to stab herself in the stomach. Second Gray Decl. (doc. no. 54–1) ¶ 47. During the same time period, the Huntsville clinic experienced an increased number of calls from women who lived far away seeking abortions, some of whom said "outright that they would try to self-induce an abortion because they could not reach a provider." Second Johnson Decl. (doc. no. 54–2) ¶ 49. Recently, Tuscaloosa's medical director has treated multiple women who attempted to self-abort, such as a woman who consumed turpentine after consulting the Internet and learning about its use as a folk remedy. [14] Tr. Vol. II (doc. no. 111) 69:1–9. So too can Alabama expect an increased level of self-abortions if the school-proximity law were to take effect. [15]

***13** In summary, because the Tuscaloosa and Huntsville clinics provide more than 70 % of abortions in Alabama and are the only providers of abortions beginning at 15 weeks of pregnancy, and because the two clinics would have to cease operations if the school-proximity law were to go into effect, the availability of abortions in Alabama would be significantly reduced, and abortions beginning at 15 weeks would become almost wholly unavailable. Thus, Alabama women attempting to obtain a pre-viability abortion would experience substantial, and even insurmountable, burdens if the school-proximity law were to take effect.

* * *

[8] As stated above, "the more severe the obstacle a regulation creates, the more robust the government's justification must be, both in terms of how much benefit the regulation provides towards achieving the State's interests and in terms of how realistic it is the regulation will actually achieve that benefit." *Planned Parenthood Se.*, 9 F.Supp.3d at 1287. Here, because, as the judicial record reflects, the State's interests are so attenuated and because, as the judicial record further reflects, the school-proximity law would place substantial, and even insurmountable, burdens on Alabama women seeking to exercise their right to a pre-viability abortion, the court concludes that the law does not "confer[ ] benefits sufficient to justify the burdens upon access that [it] imposes." *Whole Woman's Health*, 136 S.Ct. at 2300. [16] The court thus holds that the school-proximity law "constitutes an undue burden on abortion access" and is unconstitutional. *Id.*

C. State's Other Arguments

[9] In its attempt to justify its regulatory approach, the State argues—relying principally on First Amendment

challenges to zoning decisions—that governments routinely regulate the types of businesses that may operate near schools. *See, e.g.*, Def. Br. (doc. no. 81) at 44 (" '[T]here can be little doubt about the power of a state to regulate the environment in the vicinity of schools ... by exercise of reasonable zoning laws.' " (quoting *Larkin v. Grendel's Den, Inc.*, 459 U.S. 116, 121, 103 S.Ct. 505, 74 L.Ed.2d 297 (1982)). That argument misapprehends the nature of the undue-burden analysis, which is the controlling standard here. As the Supreme Court reaffirmed in *Whole Woman's Health*, the undue-burden analysis requires the court to consider, based on the judicial record, "the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S.Ct. at 2309. That analysis must have bite: it would be erroneous to "equate the judicial review applicable to the regulation of a constitutionally protected liberty with the less strict review applicable where, for example, economic legislation is at issue." *Id.* In zoning cases, the government's authority is "undoubtedly broad," but "the standard of review is determined by the nature of the right assertedly threatened or violated rather than by the power being exercised or the specific limitation imposed." *Schad v. Borough of Mount Ephraim*, 452 U.S. 61, 68, 101 S.Ct. 2176, 68 L.Ed.2d 671 (1981). Thus, in government regulation of liquor establishments in the vicinity of schools, "judicial deference is the watchword." *Davidson v. City of Clinton, Miss.*, 826 F.2d 1430, 1433 (5th Cir. 1987) (upholding a restriction on sale of alcohol within 500 feet of a school, as applied to a nightclub, as neither irrational nor arbitrary). Where constitutionally protected interests that warrant more searching review are threatened, by contrast, the State's cited examples for government regulation of the areas around schools have not withstood scrutiny and therefore do not support the State's position. *See, e.g.*, *Larkin*, 459 U.S. at 117, 103 S.Ct. 505 (invalidating, on Establishment Clause ground, statute that delegated authority to schools and churches to veto liquor licenses within 500 feet of their premises).

***14** Similarly, the State's reliance on the First Amendment 'secondary effects' doctrine of *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41, 106 S.Ct. 925, 89 L.Ed.2d 29 (1986), is mistaken. In that case, the Supreme Court upheld a city ordinance prohibiting adult movie theatres from operating within 1,000 feet of a school because the ordinance advanced the State's interests in eliminating the "undesirable secondary effects" of the theatres, such as crime, injury to retail trade, and depressed property values. 475 U.S. at 48–49, 106 S.Ct. 925. The State here asserts that it too has an interest in regulating "the undesirable secondary effects" of abortion clinics, implying the demonstrations and the impact on children who witness them are the secondary effects the law sought to curtail. Def. Br. (doc. no. 81) at 47. But the secondary-effects doctrine justifies only those State actions that would otherwise constitute an impermissible content-based infringement of First Amendment rights, which are not implicated here. Further, the Supreme Court has squarely rejected the doctrine's applicability to speech viewed as disturbing or offensive, specifically concluding that "[l]isteners' reactions to speech are not the type of 'secondary effects' we referred to in *Renton*." *Boos v. Barry*, 485 U.S. 312, 321, 108 S.Ct. 1157, 99 L.Ed.2d 333 (1988); *accord Reno v. Am. Civil Liberties Union*, 521 U.S. 844, 867–68, 117 S.Ct. 2329, 138 L.Ed.2d 874 (1997) (rejecting application of *Renton*'s secondary-effects doctrine to statute intended to protect children from offensive speech). Thus, even under *Renton*, the State could not force abortion clinics to relocate based on parents' reactions to protester speech.

Moreover, if the State seeks to regulate the areas around schools, other approaches could more effectively advance its asserted interests. For example, the State could have enacted a reasonable "time, place, and manner" restriction on demonstrations outside facilities "where abortions are offered or performed." *McCullen v. Coakley*, —— U.S. ——, 134 S.Ct. 2518, 2530–32, 189 L.Ed.2d 502 (2014) (approving such a buffer zone because it advanced public safety objectives in light of evidence of crowding, obstruction, and violence). Of course, it is not the province of this court to prescribe the most appropriate regulatory approach; however, it is worth noting that the court's decision does not leave the State without recourse to limit students' exposure to demonstrators.

The court's holding that the school-proximity law is unconstitutional still obtains.

VI. THE FETAL-DEMISE LAW

The court now turns to whether the fetal-demise law imposes an undue burden on women's access to pre-viability abortion in Alabama.

The Alabama Unborn Child Protection from Dismemberment Abortion Act, which the court calls the fetal-demise law, imposes a criminal penalty on physicians who purposely perform 'dismemberment abortions,' defined as "dismember[ing] a living unborn child and extract[ing] him or her one piece at a time from the uterus through use of clamps, grasping forceps, tongs, scissors, or similar instruments." 1975 Ala. Code § 26–23G–2(3). A health exception applies if the physician in reasonable medical judgment decides "the child's mother has a condition that so complicates her medical condition that it necessitates the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." 1975 Ala. Code § 26–23G–2(6). A physician found to be in violation of this law may face a civil suit or a criminal penalty, consisting of either a fine of up to $ 10,000, imprisonment for up to two years, or both. While not mentioned explicitly in the language of the law, the parties agree that it would ban the most common method of abortion administered in Alabama at or after 15 weeks —standard D & E—if used without first inducing fetal demise. [17]

The question before the court is whether the fetal-demise law has the purpose or effect of placing a substantial obstacle in the path of a woman's choice to obtain a pre-viability abortion. *Whole Woman's Health*, 136 S.Ct. at 2309 (quoting *Casey*, 505 U.S. at 878, 112 S.Ct. 2791 (plurality opinion)) ("[U]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right"). If it does, the law cannot stand.

***15** **[10]** **[11]** **[12]** **[13]** **[14]** This *Casey* undue-burden standard requires the court to "examin[e] the regulation in its real-world context" to determine whether the obstacles imposed by the law are substantial. *Planned Parenthood Southeast, Inc. v. Strange*, 33 F.Supp.3d 1330, 1337 (M.D. Ala. 2014) (Thompson, J). In so doing, the court must consider both the effect of an abortion statute on the availability of abortion and the health risks the statute imposes on women. "[R]egulations which do no more than create a structural mechanism by which the State ... may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose." *Gonzales v. Carhart*, 550 U.S. 124, 146, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007) (internal citations and quotations omitted). Further, "the fact that a law which serves a valid purpose ... has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id.* at 158, 127 S.Ct. 1610. However, a statute designed to protect fetal life imposes a substantial obstacle, and therefore an undue burden, where it "forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed" or "subject[s] women to significant health risks." *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976). Further, a law requiring the substitution of certain abortion procedures over others will not be upheld if it has the effect of inhibiting the vast majority of pre-viability abortions after a certain week threshold, and the law must allow continued use of "a commonly used and generally accepted method." *Gonzales*, 550 U.S. at 165, 127 S.Ct. 1610; *see Stenberg v. Carhart*, 530 U.S. 914, 945, 120 S.Ct. 2597, 147 L.Ed.2d 743 (2000) (holding that a law prohibiting the most common second-trimester abortion method, standard D & E, would impose an undue burden). A ban on a particular method can "be upheld only if there [are] safe alternative methods" available. *Danforth*, 428 U.S. at 77, 96 S.Ct. 2831.

For the reasons discussed below, the court finds the fetal-demise law effectively terminates the right to abortion for Alabama women at 15 weeks. Because it imposes an undue burden on the right of women in Alabama to obtain a pre-viability abortion, the court holds the fetal-demise law unconstitutional.

A. State's Interests

Because no legislative findings accompany the fetal-demise law, the court does not have an explanation from the legislature of the purpose for the law. The State argues that the law advances these interests: advancing respect for human life; promoting integrity and ethics of the medical profession; and promoting respect for life, compassion, and humanity in society at large. [18] The court assumes the legitimacy of these interests. *See Whole Woman's Health*, 136 S.Ct. at 2310 (assuming that the State had legitimate state interests where the statute did not contain any legislative findings).

In any event, this court must now, based on the judicial record, make its own findings. *Whole Woman's Health*, 136 S.Ct. at 2310 ("[T]he relevant statute here does not set forth any legislative findings. Rather, one is left to infer that the legislature sought to further a constitutionally acceptable objective.... For a district court to give significant weight to evidence in the judicial record in these circumstances is consistent with this Court's case law.").

B. Burdens Imposed on Women

The plaintiffs assert that the fetal-demise law makes the safest and most common method of second-trimester abortions, standard D & E, essentially unavailable, therefore imposing an undue burden on Alabama women's right to pre-viability abortions. The State responds that fetal demise can be safely achieved before standard D & E with one of three procedures: umbilical-cord transection, potassium-chloride injection, and digoxin injection.

For the reasons discussed below, the court finds that the fetal-demise law imposes a substantial burden in at least two interacting ways: first, the law imposes significant health risks on most women who choose to have an abortion by requiring them to undergo a fetal-demise procedure that is unsafe or experimental; second, and as a result, the law makes standard D & E—the only method of second-trimester abortion available in Alabama as a practical matter—largely unavailable because no safe, non-experimental methods are feasible in the vast majority of cases.

*16 Based on the following factual findings, the court concludes that the proposed fetal-demise methods are not feasible in the plaintiff clinics and that requiring the use of those methods would pose a substantial obstacle to women seeking second-trimester abortions in the State.

1. Impact on Health of Women Seeking Abortions in Alabama

The court's determination whether the law imposes a substantial obstacle to abortion access turns on whether the statute would effectively ban the most common second-trimester abortion method by requiring a procedure that is either unavailable or unsafe. *See Stenberg*, 530 U.S. at 945, 120 S.Ct. 2597 (finding that outlawing the most common second-trimester abortion method, standard D & E, would impose an undue burden upon a woman's right to terminate her pregnancy before viability). In *Gonzales*, the Court applied the *Casey* undue-burden standard to determine whether the federal Partial-Birth Abortion Ban Act of 2003 created a substantial obstacle to abortion access. *Gonzales v. Carhart*, 550 U.S. 124, 146, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007). In so doing, the Court spent a substantial portion of the opinion examining whether the Act would proscribe standard D & E, which, as will be discussed in detail below, is the most common method of performing abortions at and after 15 weeks, and is the same method at issue here. The *Gonzales* Court found that the federal ban would not substantially decrease the availability of second-trimester abortions because it prohibited only intact D & E, which was rarely administered, and because the law still allowed "a commonly used and generally accepted method", namely, standard D & E. *Gonzales*, 550 U.S. at 165, 127 S.Ct. 1610. The Court then addressed whether the ban would impose serious health risks on women. *Gonzales*, 550 U.S. at 161, 127 S.Ct. 1610.

Here, the parties agree the fetal-demise law bans standard D & E, the most commonly used method for second-trimester abortions in Alabama, when performed without first inducing fetal demise. The parties also agree that, if there are not safe methods available for inducing fetal demise, the law is unconstitutional. Thus, the court turns to an examination of the availability of the fetal-demise methods proposed by the State and the health risks they impose on women seeking abortion in Alabama. If the fetal-demise requirement prevents women from obtaining pre-viability abortions or exposes women to significant health risks, the requirement would impose an undue burden on their constitutional right to choose a pre-viability abortion.

a. Standard D & E

Before addressing the State's proposed methods for inducing fetal demise, the court now provides background on the current landscape of second-trimester abortions in Alabama. The vast majority of second-trimester abortions in Alabama are performed using "standard D & E."[19] Standard D & E is a surgical abortion method that consists of two parts: dilation of the cervix (the "D") and

evacuation of the uterus (the "E"). Robinson White Decl. (doc. no. 54–4) ¶ 20. First, a woman's cervix is dilated only enough to allow passage of surgical instruments. Then, the physician evacuates the uterus using forceps to grasp the fetus and remove it, and using suction to remove remaining contents of the uterus. It is important to open the cervix gently, and then only a small amount, for safety reasons and to preserve it for future pregnancies. Tr. Vol. I (doc. no. 110) at 16:5–12. Because the opening of the cervix is too small for the entire fetus to pass, separation of fetal tissues occurs during the process of removing the fetus. *Id.* at 17:6–14. Due to this separation of tissues, standard D & E falls under the fetal-demise law's definition of 'dismemberment abortions.' Physicians start using the standard D & E procedure around 15 weeks of pregnancy, before which they can remove the fetus using only suction.

*17 Standard D & E is considered an extremely safe abortion method, with a less than 1 % chance of major complications. *Id.* at 17:17–18. Nationally, about 95 % of second-trimester abortions are performed through standard D & E. Davis Decl. (doc. no. 54–5) ¶ 7. Standard D & E is also the only abortion method that can be performed in an outpatient setting in Alabama at or after 15 weeks. Second Parker Decl. (doc. no. 54–6) ¶ 14; Tr. Vol. I (doc. no. 110) at 189:8–11. Typically, standard D & E is performed in one day. [20] Robinson White Decl. (doc. no. 54–4) ¶ 20. After dilation, the procedure takes between 10 to 15 minutes. *Id.* at 17:15–16.

Due to its low risk of complications, relative simplicity, and short duration, standard D & E is the most common method of second-trimester abortion in Alabama. Second Parker Decl. (doc. no. 54–6) ¶ 14; Robinson White Decl. (doc. no. 54–4) ¶ 23. The ability to perform standard D & E in one day and in outpatient settings is particularly important because the vast majority of women seeking abortions in Alabama rely on outpatient clinics. Alabama hospitals provide very few abortions: in 2014, hospitals provided 23 abortions in 2014, which amounted to less than 0.3 % of all abortions in the state. Donald Decl. Exs. C & F, Induced Terminations of Pregnancy Occurring in Ala. (doc. no. 81–14). [21] Of those 23 abortions performed in hospitals, seven were performed after 15 weeks of pregnancy: six of these were induction abortions, and the seventh was by standard D & E. *Id.* Induction is the only alternative to standard D & E in Alabama after 15 weeks of pregnancy and is not available in outpatient clinics. [22] Robinson White Decl. (doc. no. 54–4) ¶ 24. In other words, outpatient clinics performed standard D & E for 99 % of women undergoing abortions at or after 15 weeks of pregnancy in Alabama in 2014. Donald Decl. (doc. no. 81–14). The Tuscaloosa and Huntsville clinics are the only outpatient clinics in Alabama providing standard D & E procedures. Accordingly, these two clinics performed 99 % of abortions at or after 15 weeks in Alabama in 2014.

b. Umbilical–Cord Transection

*18 [15] One of the methods the State proposes the Alabama clinics use to induce fetal-demise is umbilical-cord transection. To perform umbilical-cord transection incident to standard D & E, the physician must first dilate the woman's cervix enough to allow the passage of instruments to transect the cord. Once the cervix is dilated, the physician uses an ultrasound machine to visualize the umbilical cord. The physician then punctures the amniotic membrane, inserts an instrument into the uterus, and tries to find the cord with a surgical instrument and cut it. The physician must then wait for the fetus to achieve asystole, or cessation of heart activity. Tr. Vol. II (doc. no. 111) at 123:8–124:18; *see* Tr. Vol. I (doc. no. 110) at 77:13–78:7. Once asystole has occurred, the physician can perform standard D & E, removing fetal tissues and other contents of the uterus.

The court finds that, for the following reasons, inducing fetal demise with umbilical-cord transection prior to conducting standard D & E is not feasible or safe in the plaintiff clinics, and therefore is not a method that allows the plaintiffs to comply with the fetal-demise law.

(i) Multiple factors make cord transaction technically difficult, and sometimes impossible, before a standard D & E procedure: lack of visualization; continuous shrinking of the uterus during the procedure; and the size of the umbilical cord. First, a physician performing umbilical-cord transection must be able to do so without much visual aid. Before the amniotic membrane is punctured, the physician is readily able to visualize the fetus and the umbilical cord due to the contrast on the ultrasound between the amniotic fluid and the uterine and fetal tissue. However, when the amniotic membrane is punctured at the beginning of the procedure, the amniotic fluid drains from the uterus. Once the fluid has drained, it

is much more difficult to visualize the location of the umbilical cord because the contrast dissipates along with the amniotic fluid. Tr. Vol. I (doc. no. 110) at 77:16–78:17. Second, as the fluid drains, the uterus contracts, pushing the contents of the uterus against each other. *Id.* Depending on the gestational age, the cord may be very thin; at 15 weeks, it is the width of a piece of yarn.[23] Finally, as the fluid drains out of the uterus, the cord may become flaccid, making it harder to find. *Id.* As a result, the umbilical-cord transection method requires a physician to identify, reach, and transect a flimsy, roughly yarn-sized cord without any visualization aid or space between different types of tissues; should the physician fail and grasp the fetal tissues, she could be subject to prosecution for conducting a "dismemberment abortion" under the fetal-demise law. *Id.*

(ii) Cord transection carries significant health risks to the patient, including blood loss, infection, and injury to the uterus. *See Gonzales*, 550 U.S. at 161, 127 S.Ct. 1610 (reiterating the Court's jurisprudence that abortion regulations that pose "significant health risks" are unconstitutional). Performing cord transection before standard D & E to achieve fetal demise involves a heightened risk of serious blood loss compared to performing standard D & E alone. Cord transection is a risky procedure: one of the experts in this case had first-hand experience of attempting to perform cord transection to comply with the federal ban on intact D & E in a hospital setting. She credibly testified that she and her colleagues stopped attempting the procedure because of concerns about patient safety. In their experience, it took as long as 13 minutes after cutting the cord for the heartbeat to stop; and, while waiting for the fetal heart to stop, the patients were having contractions, undergoing placental separation, and losing blood, which caused the physicians great concern for the safety of their patients. Tr. Vol. I (doc. no. 110) at 82:21—83:11. As a result, the expert and her colleagues abandoned the idea of using cord transection as a standard practice before intact D & E.[24] *Id.* at 83:4–15.

*19 Moreover, cord transection increases the risk of infection and uterine perforation compared to standard D & E. Every time a physician introduces an instrument into the uterus, there is a risk of infection or uterine perforation; this risk increases with every pass of the instrument. Tr. Vol. I (doc. no. 110) at 80:1–16. As performing cord transection involves searching blindly for the umbilical cord—which can take several passes prior to the passes needed to perform standard D & E—the risk of complications is greater than when performing standard D & E alone.

These risks would be amplified in the outpatient setting of the Tuscaloosa and Huntsville clinics, where all abortions in Alabama at or after 15 weeks take place. Unlike physicians practicing in hospitals, the clinic physicians do not have access to blood services for patients at risk of serious blood loss, nor do they have access to subspecialists such as anesthesiologists. Moreover, the medical equipment at the plaintiffs' clinics, such as the ultrasound machines crucial to cord transection, is not as advanced as what is available in tertiary-care hospital settings. Tr. Vol. I (doc. no. 110) at 236:9–18. The lack of these services and technologies would undoubtedly increase the risks of the procedure.

(iii) Umbilical-cord transection is also not a feasible method because it is, for all intents and purposes, an experimental procedure.[25] The State argues that umbilical-cord transection is a viable, safe option before standard D & E based on a single study—that is, the only existing study that has examined umbilical-cord transection as a method for fetal demise before D & E. But the study raises more questions than it answers.

The study suffers from several flaws that render it unreliable. First, the article was a retrospective case series study, which means that the researchers were trying to answer a question by going through medical records after the data was collected for purposes other than research. While not the least reliable type of study, it is one of the least reliable. Because the study relies on medical records from a non-research context, there is no way of knowing how the underlying data was collected, or what data was omitted from the records. Tr. Vol. I (doc. no. 110) at 84:3–20. The study states that close to 10 % of the original study group was excluded for incomplete records. Kristina Tocce et al., *Umbilical Cord Transection to Induce Fetal Demise Prior to Second–Trimester D & E Abortion*, 88 Contraception 712, 713 (2013) (doc. no. 81–13).

Further, because of the study design, the article is missing details that would reliably establish risk levels. It did not utilize a control group, so there is no way to compare the outcomes of the group that received cord transection and a group that did not receive cord transection. The study

also does not report how much time or how many passes it took to successfully grasp and transect the cord in each case; as explained above, the more passes with instruments in the uterus, the greater the risk of injury to the uterus and infection. Finally, the study does not report week-by-week distribution of gestational age of the subjects, even though the success rate of cord transection procedures would be expected to vary across the gestational age due to the changing size of the umbilical cord. Tr. Vol. I (doc. no. 110) at 83:23—86:13; 125:14–22.

*20 Moreover, the resources of the facility where the transections in the study were performed are not comparable to those of the Tuscaloosa and Huntsville clinics. The patients in the study underwent intracervical anesthetic blocks and IV sedation during the cord transection and D & E procedures, Tocce et al., *supra*, at 713 (doc. no. 81–13), neither of which are available at the Tuscaloosa and Huntsville clinics, Tr. Vol. II (doc. no. 111) at 11:2–20; Tr. Vol. I (doc. no. 110) at 137:9–24. Comparing the study conditions to the Tuscaloosa and Huntsville clinics appears to be like comparing apples to oranges; the study provides paltry evidence as to the safety of performing the procedure in the Alabama clinics.

Cord transection carries serious risks, and insufficient research has been conducted to quantify those risks. Requiring cord transection before standard D & E would force physicians to perform a medically unnecessary procedure without much, if any, information about the likelihood of harm to the patient. Further, the law would force women to accept an experimental procedure and exposure to a potentially grave risk of harm as the cost of undergoing standard D & E, which is well-documented for its low risks.

(iv) Not surprisingly given the potential health risks and the experimental nature of cord transection prior to D & E, no training is available for doctors within Alabama to learn to perform this procedure. The physicians at the Tuscaloosa and Huntsville clinics have not been trained in this technically challenging procedure, and they are unlikely to be able to get any training: because cord transection is not common, it would be difficult for physicians to find cases to observe, especially in the early part of the second trimester. Further, given the climate of hostility and the difficulty of hiring doctors willing and able to perform abortions in Alabama, attracting doctors already trained in the procedure to work in the Huntsville and Tuscaloosa clinics is unlikely. The lack of training opportunities and the inability to recruit trained physicians renders the procedure unavailable in Alabama as a practical matter.

(v) The risk of harm associated with cord transection supports the plaintiff physicians' credible and valid concerns about being forced to perform this procedure under the fetal-demise law. Tr. Vol. I (doc. no. 110) at 212:4–14; Tr. Vol. II (doc. no. 111) at 48:24–49:6. Physicians have an ethical obligation not to subject patients to potentially harmful, experimental procedures without any medical benefit and the patient's consent. The fetal-demise law forces women to either undergo a risky procedure with no any medical benefit or give up their right to pre-viability abortion; placing women in such a predicament negates any opportunity for meaningful consent.

* * *

In sum, the court finds that the technical difficulties of performing umbilical-cord transection, combined with the potential for serious harm, the experimental, virtually unstudied nature of the procedure, and the unavailability of training, render umbilical-cord transection unavailable as an option for the plaintiffs to comply with the fetal-demise requirement. Thousands of women cannot be required to undergo a risky procedure based on one questionable study. *See Danforth*, 428 U.S. at 79, 96 S.Ct. 2831 (striking down an abortion method ban where the alternatives proposed by the State were largely experimental and unavailable to women in that State).

c. Potassium–Chloride Injection

[16] Another method the State proposes the Alabama clinics use to induce fetal-demise is potassium-chloride injection. Physicians administer potassium-chloride injections by inserting a long surgical needle through the woman's skin, abdomen, and uterine muscle, and then into the fetal heart, using an ultrasound machine to guide the needle. When administered directly to the fetal heart, potassium chloride stops it almost immediately. Potassium-chloride injections are invasive and painful, because they are administered through a transabdominal surgical needle without anesthesia. Tr. Vol. I (doc. no.

110) at 44:12–22; 75:25—76:6; 196:3–6. The procedure is generally performed as a means of selective fetal reduction—where one or more of fetuses in the same pregnancy are terminated and the rest are carried to full-term—or during labor-induction abortions, which may not be provided in outpatient settings and very rarely performed in Alabama. Tr. Vol. I (doc. no. 110) at 37:10–20; Donald Decl. Ex. F, Induced Terminations of Pregnancy 2014 Report (doc. no. 81–14) at 19 (showing that outpatient clinics performed no induction abortions in 2014).

***21** The court finds that potassium-chloride injections are not an available method for causing fetal demise before standard D & E procedures in plaintiffs' outpatient clinics for the following reasons.

(i) Physicians must receive extensive training to induce fetal demise through injection of potassium chloride, and that training is unavailable to abortion providers at outpatient clinics in Alabama. Injecting potassium chloride takes great technical skill and is extremely challenging. The physician's goal is to inject it directly into the fetal heart, which is smaller than the size of a dime at 15 weeks of pregnancy.[26] Tr. Vol. I (doc. no. 110) at 31:11. Accidentally injecting potassium chloride into the woman's body can cause significant harm, such as cardiac arrest. Potassium-chloride injection is not taught to OB/GYN residents or to family-planning fellows, whose training involves abortion care, because it is generally used only for high-risk, multi-fetal pregnancy reductions.[27] Tr. Vol. I (doc. no. 110) at 39:9–25. The only subspecialists who are trained to perform the injections are maternal-fetal medicine fellows, who complete three years of highly supervised training to specialize in high-risk pregnancies. Tr. Vol. II (doc. no. 111) at 141:5–10. Learning to perform these injections safely would require observing approximately 100 to 200 procedures. *Id.* at 60:7—61:9.[28]

Because the plaintiff physicians have not been trained in potassium-chloride injections, they would need to receive training in order for this procedure to be a meaningfully available method.[29] However, it would be impossible for these physicians to receive this specialized training, because no hospital in Alabama offers training on potassium-chloride injections to unaffiliated physicians not enrolled in their three-year maternal-fetal medicine fellowship program. Tr. Vol. II (doc. no. 111) at 141:23–25. Furthermore, because even a major academic hospital such as the University of Alabama at Birmingham has a caseload of fewer than 10 potassium-chloride injection procedures per year, even a hypothetical ad-hoc training program would take more than 10 years for a sufficient number of cases to arise. *Id.* at 140:6–10.

***22** (ii) Potassium-chloride injections carry serious risks to the patient. Because potassium chloride has harmful effects on the heart, inadvertently injecting it into the woman's circulation can endanger the patient. Tr. Vol. I (doc. no. 110) at 29:2–7; Biggio Decl. (doc. no. 81–1) ¶ 9. In one instance reported in the medical literature, a woman suffered cardiac arrest because potassium chloride was accidently injected into one of her blood vessels instead of the fetus. Tr. Vol. I (doc. no. 110) at 42:2–8. Injections of potassium chloride may also increase the risk of uterine perforation and infection, due to the inherent risks associated with transabdominal injections. *Id.* at 29:3–5, 43:16–22, 80:6–8; Tr. Vol. II (doc. no. 111) at 21:5–9. No systemic study on the efficacy or safety of the procedure before standard D & E is available, rendering the procedure experimental. Tr. Vol. I (doc. no. 110) at 29:21–30:3, 44:4–11.

(iii) Physical conditions common to many women can make potassium-chloride injection extremely difficult or impossible. Obesity, fetal and uterine positioning, and presence of uterine fibroids may complicate or even prevent the administration of the injections in many women. Tr. Vol. I (doc. no. 110) at 40:4–42:1.

First, obesity can make it difficult for physicians to guide the needle through the abdomen into the uterus, for two reasons: the additional tissue in the patient's abdomen reduces the quality of the ultrasound images, making it more difficult to find the fetus; and the needle must travel through more tissue in order to get to the uterus. Tr. Vol. I (doc. no. 110) at 40:11–20, 61:1–6; Tr. Vol. II (doc. no. 111) at 139:3–15. Obesity is common in the Tuscaloosa and Huntsville clinics' patient population; indeed, about 40 % of the patients at the Huntsville clinic are obese. Tr. Vol. I (doc. no. 110) at 197:1–2; Tr. Vol. II (doc. no. 111) at 61:17–19. Second, fetal and uterine positioning can affect whether the physician is able to get to the fetus with a needle. Tr. Vol. I (doc. no. 110) at 61:18–25. Because fetal positioning changes throughout pregnancy, a doctor is unable to know whether fetal and uterine positioning pose a problem for the injection until the woman receives

an ultrasound immediately prior to the procedure. Third, uterine fibroids, which are benign tumors on the uterine walls affecting over half of women, can get in the needle's way, because they can become calcified and impenetrable. Tr. Vol. I (doc. no. 110) at 40:21–41:4, 61:18–25, 197:3–4. All four of these factors can make it difficult—or even impossible—for the needle to reach the fetus or even the amniotic fluid. Thus, many women seeking abortions in Alabama would not be good candidates for potassium-chloride injections.

* * *

Because it is a technically challenging procedure that carries serious health risks, because there is no practical way for the plaintiffs or any other outpatient abortion providers in Alabama to receive training to perform the procedure safely, and because common conditions would render the administration of potassium-chloride difficult or impossible for many women who seek second-trimester abortions in Alabama, the court finds potassium-chloride injection unavailable as a method for achieving fetal demise.

d. Digoxin Injection

[17] The final method that the State argues the Alabama clinics could use to induce fetal-demise prior to standard D & E is digoxin injection. To inject digoxin, physicians begin by using an ultrasound machine to visualize the woman's uterus and the fetus. The physician then inserts a long surgical needle through the patient's skin, abdomen, and uterine muscle, in order to inject digoxin into the fetus. If the attempt to inject into the fetus fails, the physician may inject digoxin into the amniotic fluid, but evidence suggests this is generally less effective. Digoxin injection, when it works, takes up to 24 hours to stop the fetal heart. Physicians cannot accurately predict how long digoxin will take to work in a given patient. Tr. Vol. I (doc. no. 110) at 59:25–60:11, 68:6–9. As with potassium-chloride injections, digoxin injections are painful and invasive because they are administered through a transabdominal needle without anesthesia. Tr. Vol. I (doc. no. 110) at 44:12–22, 75:25–76:6, 196:3–6.

*23 The court concludes that digoxin injections are not a feasible method of causing fetal demise in the Alabama clinics for the following reasons.

(i) First, digoxin injections are not reliable for inducing fetal demise. When injected into the fetus or amniotic fluid, digoxin has a failure rate ranging between 5 % and 15 %. Tr. Vol. I (doc. no. 110) at 64:1–8; Tr. Vol. II (doc. no. 111) at 142:4–10. The State suggested that when fetal demise is not successful after the first injection, a second injection of digoxin could be attempted. However, no study has established the appropriate dosage, potential risks, or time to fetal demise for administering a second injection of digoxin. Tr. Vol. II (doc. no. 111) at 142:12–25. Further, performing a second injection is not acceptable medical practice because its safety remains untested. Davis Decl. (doc. no. 54–5) ¶ 28. The State further argued that, in those 5 to 15 % of cases where an initial digoxin injection failed, the physician could try a different method of fetal demise. But, as discussed earlier, there are no other viable methods in the plaintiff clinics. Requiring digoxin injection would force women to undergo an unreliable method of fetal demise, and, in cases where fetal demise is not achieved by the first injection, would mandate physicians to experiment with the right dosage for the second injection.

(ii) The lack of reliability is compounded by the fact that, as with potassium-chloride injections, a variety of factors, such as uterine positioning, fetal positioning, obesity, and the presence of uterine fibroids, can affect whether the physician is able to inject digoxin into the fetus or the amniotic fluid successfully. As noted above, a high percentage of the patients at the plaintiff clinics are obese, and over half of all women suffer from fibroids. Further, uterine and fetal positioning can make the injection impossible, and cannot be predicted ahead of the procedure. As a result, digoxin injections will not be possible for many patients seeking to have an abortion at the plaintiff clinics.

(iii) Digoxin injections are experimental during the time period when most Alabama women receive abortions using the D & E procedure. The majority of studies on digoxin injection focus on pregnancies at or after 18 weeks: only a few studies have included cases at 17 weeks, and no study has been done on the efficacy, dosage, or safety of injecting digoxin into women before 17 weeks of pregnancy. Tr. Vol. I (doc. no. 110) at 67:7–14; Tr. Vol. II

(doc. no. 111) at 143:18–25. Because there are no studies for this gestational period, digoxin injections remain experimental for women before 18 weeks of pregnancy—the period during which most second-trimester abortions in Alabama are performed. Donald Decl. Ex. C, Induced Terminations of Pregnancy Occurring in Ala. (doc. no. 81–14) (showing that 80 % of abortions performed in 2014 at or after 15 weeks occurred between 15 to 18 weeks). As with the experimental nature of umbilical-cord transection, requiring digoxin injection before 18 weeks of pregnancy would force women to go through an experimental, potentially harmful medical procedure.

***24** (iv) Even when effective at inducing fetal demise with one dose at or after 18 weeks, digoxin injections carry significant health risks. The parties' experts agreed, and the court so finds, that digoxin injections are associated with heightened risks of infection, hospitalization, and spontaneous labor and extramural delivery—that is, the unexpected and spontaneous expulsion of the fetus from the uterus while the woman is outside of a clinic setting without any medical help—compared to standard D & E alone. There is no dispute among experts that digoxin injection is six times more likely to result in hospitalization compared to injection of a placebo; that it carries an increased risk of infection over standard D & E; and that it is twice as likely as amniocentesis[30] to result in extramural delivery. Tr. Vol. I (doc. no. 110) at 170:22–171:2, 153:15–154:6; Tr. Vol. II (doc. no. 111) at 153:2–8. Spontaneous expulsion of the fetus can cause bleeding and require medical attention, aside from being very upsetting to the woman.[31] Because of these documented risks, the Society of Family Planning, a professional organization for family planning, stated that in order to justify "the harm of the documented increase in spontaneous labor and extramural delivery, along with an increase in vomiting seen in the one blinded digoxin RCT [randomized control trial], in addition to any more infrequent risks, a significant increase ... in D & E safety would seem warranted." Tr. Vol. I (doc. no. 110) at 26:20–24, 28:2–7.[32]

One of the plaintiffs' experts testified that between 2007 and 2011, in order to avoid the risk of violating the federal partial-birth abortion ban, his former employer required digoxin injections for abortions at or after 20 weeks. Tr. Vol. II (doc. no. 111) at 82:5–12. This was before more research on digoxin injections showed that the procedure carries significant risks of extramural delivery, infection, and hospitalization. Tr. Vol. I (doc. no. 110) at 70:6–71:16. The expert explained that his former employer's past practice is distinguishable from legally requiring digoxin use before all standard D & E for two reasons. First, in the case of the employer's elective digoxin use, when the first dose failed, the physician could stop attempting fetal demise and perform standard D & E without facing criminal liability; therefore, the physician was not required to administer an experimental second dose of digoxin. Second, the policy was never applicable to pregnancies before 18 weeks, because it would have been experimental for those women. In other words, even before research showed that digoxin injections carry significantly greater risks of extramural delivery and hospitalization, digoxin injections were never used for pregnancies before 18 weeks—the time during which the majority of second-trimester abortions in Alabama are sought. Were the fetal-demise law to go into effect here, in contrast, the physicians would have to use digoxin before 18 weeks, and would have no other, non-experimental option were the first injection unsuccessful; the patient would simply be unable to have an abortion.

***25** (iv) The use of digoxin injections as a fetal-demise method would impose serious logistical obstacles to abortion access. For the vast majority of women in Alabama, standard D & E is a one-day procedure. Second Parker Decl. (doc. no. 54–6) ¶ 13; Robinson White Decl. (doc. no. 54–4) ¶ 20. Requiring a digoxin injection increases the procedure from one day to two: women undergoing digoxin injection would be required to make an additional trip to the clinic 24 hours prior to their D & E procedure appointment for the injection. *See Whole Woman's Health*, 136 S.Ct. at 2313 (external factors that affect women's ability to access abortion care—such as increased driving distance—should be considered as an additional burden when conducting the undue burden analysis). This would be in addition to the counseling session and 48–hour waiting period mandated by Alabama law. Accordingly, if digoxin injection were used to induce fetal demise, a patient seeking an abortion would have to meet with the physician at least three times over four days all for a 10– to 15–minute procedure: first, to receive the required informed-consent warning; second, at least 48 hours later, to undergo the digoxin injection; and third, at least 24 hours later, to have the physician determine whether fetal demise was achieved and if so, to receive the standard D & E procedure. Tr. Vol. I (doc.

no. 110) at 202:23—204:11. And, in the 5 to 15 % of cases where the first digoxin injection would fail, an additional visit would be required.

The burden of having to make multiple trips for the procedure is especially pronounced for the population of women who seek second-trimester abortions in Alabama. Most women who come to the Tuscaloosa and Huntsville clinics are low-income: 82 % of patients at the Tuscaloosa clinic live at or below 110 % of the federal poverty level, and 60 % of patients at the Huntsville clinic receive financial assistance.[33] Second Gray Decl. (doc. no. 54–1) ¶ 45; Tr. Vol. I (doc. no. 110) at 206:18–23. Travel is not free, and the burdens of additional trips is compounded by the fact that low-income patients often do not have access to a car. Second Katz Decl. (doc. no. 54–11) ¶ 22 (estimating more than one in four patients does not have access to a car). As this court found in *Planned Parenthood Southeast, Inc. v. Strange*, getting to an abortion clinic is expensive and difficult for low-income women: they are more likely to depend on public transportation, ask friends or relatives for rides, or borrow cars; they are unlikely to have regular sources of childcare; they are more likely to work for a job that pays hourly, without any paid time off, or to receive public benefits that require regular attendance of meetings or classes.[34] *Planned Parenthood Se.*, 33 F.Supp.3d at 1357; Second Katz Decl. (doc. no. 54–11) ¶ 16–34. Having to make yet another trip to the clinic in order to receive the digoxin injection would exacerbate the patients' difficulties, especially if they are traveling long distances to get to the clinic; for some of them, the procedure would become time- and cost-prohibitive. Depending on how far away from the clinic the woman lives—and some women live as far as five hours away by car, presumably far more by bus—undergoing digoxin injection before D & E could require a woman to miss four or even five days of work.[35] Faced with what will be, for many, an insurmountable financial and logistical burden, some low-income women would not be able to have an abortion at all.

* * *

***26** Because the court has found that umbilical-cord transections and potassium-chloride injections are not feasible and unsafe in the Alabama clinics, and therefore unavailable, digoxin injection is the only remaining alternative for inducing fetal demise. Based on the unreliability of the procedure, the experimental nature of the procedure for women before 18 weeks of pregnancy and for injecting a second dose of digoxin, the increased risks of complications beyond standard D & E alone, the travel burden, and the pain and invasiveness of the procedure, the court finds that digoxin injection is not a feasible method of inducing fetal demise before standard D & E in Alabama clinics.

e. Findings on Experts

Before analyzing the impact of the proposed use of these three methods on the availability of second-trimester abortion in Alabama, the court pauses here to explain certain findings with regard to the testimony of the parties' experts, both as a general matter and on particular topics.

The court makes these general findings regarding two of the experts who testified at the hearing. Dr. Anne Davis, one of the plaintiffs' experts, was highly credible and knowledgeable about the fetal-demise methods, the strengths and weaknesses of various types of studies, the provision of abortion, and, in particular, the practical realities of provision of abortion in outpatient clinics such as the Tuscaloosa and Huntsville clinics. In contrast, the court found that Dr. Joseph Biggio, the State's expert, has expertise in the provision of potassium-chloride injections in an academic medical center, but that he has significantly less expertise than the plaintiffs' experts on abortion in general, because he does not in any sense specialize in abortion and has performed far fewer such procedures. In particular, he did not evince significant knowledge of the provision of abortion in outpatient-clinic settings or the conditions that exist in those clinics, and his testimony as to digoxin injection and umbilical-cord transection was largely theoretical and not based on experience. Accordingly, the court gave his testimony less weight based on those concerns.

While the State's expert opined that umbilical-cord transection would be feasible in the Tuscaloosa and Huntsville clinics, the court found this suggestion unconvincing in part because he did not recognize the differences between the type of specialized hospital where he practices and the clinics. Dr. Biggio practices at a major academic hospital, and testified that with a certain type of advanced ultrasound machine, a physician should

be able to locate the umbilical cord easily. However, the Tuscaloosa and Huntsville clinics do not have these advanced ultrasound machines, and these devices cost $ 50,000 to $ 100,000. Tr. Vol. I (doc. no. 110) at 43:10 13, 198:16 199:9. Likewise, in the case that a patient experienced significant blood loss during the umbilical-cord transection procedure, Dr. Biggio would have the resources of a major hospital—including access to blood services—to address the problem, which the plaintiff clinics lack. Furthermore, the State's expert has never attempted umbilical-cord transection, which rendered his testimony far less probative than that of the plaintiff's expert, Dr. Davis, who had.

While agreeing that plaintiff physicians would need to observe a number of procedures in order to learn how to perform a potassium-chloride injection safely, Dr. Biggio estimated that it would take only 10–20 procedures for the plaintiffs to learn to inject potassium chloride for purposes of performing abortions in the outpatient clinics. Tr. Vol. II (doc. no. 111) at 119:6 14. The court viewed this estimate as unreasonably low given the technical difficulty of the procedure, the severity of the potential health risk to the woman, and the difference in technological and emergency resources between the academic hospital where the State's expert works and the plaintiffs' outpatient clinics. Based on these issues, as well the fact that the plaintiffs' expert's opinion was based on consultation with a leading expert in the use of potassium chloride, the court credited the plaintiffs' expert's testimony on this issue, and rejected that of the State's expert.

2. Impact on Availability of Second-Trimester Abortions

*27 **[18]** Having discussed the mechanisms and risks of the three proposed fetal-demise methods, the court turns to the aggregate impact of the law mandating fetal demise before standard D & E on women's access to second-trimester abortions in Alabama. As mentioned above, the undue-burden analysis requires the court to consider the "real-world" impact of the proposed regulation. Accordingly, the court considers the impact of the fetal-demise law on the availability of abortions for Alabama women at 15 or more weeks of pregnancy who would otherwise receive a standard D & E abortion at either the Huntsville or Tuscaloosa clinic.

The State argues that it has no obligation to come up with one fetal-demise method that works for all women; standard D & E itself does not work for every woman, and the State is not requiring that any specific method be used for all women because, in theory, women have three options from which to choose. However, if none of the proposed fetal-demise methods works for women who would otherwise have been able to receive standard D & E, the fetal-demise requirement would impose a substantial burden on those women. Furthermore, if available options expose women to significant health risks, the fetal-demise requirement would impose a substantial burden on women seeking to terminate their pregnancy.

Based on the factual findings discussed above, it is clear that the fetal-demise requirement would significantly reduce access to pre-viability second-trimester abortions in Alabama. The court finds it apparent that these burdens go beyond having "the incidental effect of making it more difficult or more expensive to procure an abortion," *Gonzales*, 550 U.S. at 158, 127 S.Ct. 1610; should the fetal-demise law stand, Alabama women will be altogether unable to access a safe abortion at or after 15 weeks of pregnancy.

There are a number of burdens that the vast majority of woman seeking a second-trimester abortion would face under the fetal-demise law. All women seeking a second-trimester abortion in Alabama would have to endure a medically unnecessary, invasive procedure that increases the duration of the procedure as well as the risk of complications. Davis Decl. (doc. no. 54–6) ¶ 19 ("The American Congress of Obstetricians and Gynecologists ('ACOG') has stated that there is no sound medical basis for requiring abortion providers to induce fetal demise prior to performing a D & E. According to the ACOG, 'No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion.' "). These women will be unique: there is no other medical context that requires a doctor —in contravention of her medical judgment and the best interests of the patient—to administer a procedure that delivers no benefit to the patient. *Id.* at ¶ 18. For many women, the fetal-demise law would increase the length of the procedure from one day to two—not including the mandatory visit 48 hours before attempting fetal demise—increasing all accompanying costs of travel and/or lodging. This delay and extra cost would be particularly burdensome for low-income women, many of whom end

up seeking a second-trimester abortion (rather than a first-trimester abortion) precisely because of the time it took them to gather money to cover these costs.

Other burdens of the fetal-demise law depend on the gestational period of the woman seeking the abortion, who can be put into two groups: those whose pregnancies are between 15 and 18 weeks, and those whose pregnancies are between 18 and 22 weeks.[36] The first group is significantly larger than the second group: approximately 80 % of women who obtain abortions at or after 15 weeks in Alabama do so between 15 and 18 weeks of pregnancy. Donald Decl. Ex. C, Induced Terminations of Pregnancy 2014 Report (doc. no. 81–14) at 13. This group, under the fetal-demise law, would have no avenue for obtaining an abortion in Alabama. First, as discussed above, umbilical-cord transection and potassium-chloride injections would be unsafe and are not at the plaintiff clinics; even if they were attempted, the size of the fetus at this stage of pregnancy would make the procedures extremely technically difficult. Second, digoxin injections are virtually unstudied for this group of women—no data on dosage, safety, or side effects exist; in other words, women would have to undergo an experimental procedure with significant health risks in order to have an abortion. In sum, for women between 15 and 18 weeks of pregnancy —the majority of the population affected by the law— none of the three procedures are available in any practical sense in Alabama; in other words, the fetal-demise law would operate as an absolute barrier to these women's access to pre-viability abortions.

***28** For those whose pregnancies are at 18 weeks or later, their access to pre-viability abortion would be substantially burdened by significant health risks that would be absent if not for the fetal-demise requirement. First, potassium-chloride injection is not available on an outpatient basis in Alabama. Second, while not as difficult as in pre–18 week pregnancies, cord transection is technically difficult, unreliable, and unsafe, due to the significant risk of blood loss. Third, digoxin injections increase the risk of extramural delivery, infection, and hospitalization and fail 5 to 15 % of the time, and no appropriate dosage, timing, or side effects of a second dose are known. This means that in addition to being subject to heightened risks of complications, for up to one out of every six women undergoing the procedure, digoxin would fail, and the patient would be caught between a rock and a hard place: either elect an experimental second dose of digoxin, undergo another unsafe procedure with its attendant risks at the hands of a physician with no training, or give up the right to have an abortion.

The interplay among the three proposed fetal-demise methods illustrates that each method suffers from significant flaws, thereby significantly reducing the availability of second-trimester abortions and making obtaining an abortion substantially more burdensome. The State's claim that women have three options does not negate the fact that for most women who would have been previously able to get standard D & E—a safe and commonly used procedure for women after 15 weeks of pregnancy—none of the three 'alternatives' would be safe or feasible.

Indeed, one of plaintiff's experts credibly testified about how the flaws in these fetal demise methods could be expected to interact in the real world. Dr. Davis testified that, because she was hoping to perform an intact D & E, which she believed to be safer at a later gestational age, she attempted fetal demise to comply with the federal ban on intact D & E. She first tried digoxin, which failed to work; then she attempted the potassium-chloride injection. Despite being highly trained in the field of abortion care, she was unable to successfully inject potassium chloride into the fetal heart, even at or after 20 weeks of pregnancy. Tr. Vol. I (doc. no. 110) at 52:11 —53:14, 136:7 16. She did not find it safe to perform cord transection. At that point, she still had the option of performing standard D & E without fetal demise, which is what she did. However, had the fetal demise requirement been in effect for standard D & E, she would not have been able to provide the abortion.

When a woman is forced to undergo an unwanted, risky, invasive, and experimental procedure in exchange for exercising her right to choose an abortion, her right is substantially burdened. A regulation that "as a practical matter, [ ] forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed" cannot withstand constitutional challenge. *Danforth*, 428 U.S. at 79, 96 S.Ct. 2831. Indeed, would we want ourselves, our spouses, or our children to undergo an unnecessary medical procedure for which the documented safety and effectiveness is comparably lacking? The court finds that the State should not ask otherwise of Alabama women seeking pre-viability abortions.

The State suggests that mandating fetal demise does not burden women's access to pre-viability second-trimester abortion because some doctors have chosen to perform fetal-demise procedures before standard or intact D & E. This argument fails to appreciate the distinction between elective and government-mandated surgical procedures. In the absence of a legal requirement that fetal demise must be achieved, a physician and a patient can discuss the risks and determine the best course of action for that woman's particular medical needs and based on that woman's particular desires. In that context, a physician and her patient may elect a fetal-demise procedure because the patient wants it.

On the other hand, when the State requires that every woman getting a second-trimester abortion must go through an extraneous procedure, what was an acceptable health risk in the context of a physician recommending the procedure and a patient giving informed consent turns into a much higher risk, for two reasons: first, the State is turning a rare procedure that was done only in the context of pregnancy of multiples (potassium-chloride injections) or late-stage pregnancies (digoxin injections) into a requirement for practically all women getting an abortion at or after 15 weeks, greatly increasing the number of women who are subject to the heightened health risks; second, the State is mandating the procedure on women, even for whom the procedure is especially risky, without their consent. *See Casey*, 505 U.S. at 857, 112 S.Ct. 2791 (stating that *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973) and its progeny may be seen as a rule of "bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection.").

***29** Further, the court cannot find that the health-exception functions as a fail-safe; it does not nullify the burden the fetal-demise requirement creates on women's access to second-trimester abortion. As noted earlier, the statute provides that, if the physician in reasonable medical judgment decides that "the child's mother has a condition that so complicates her medical condition that it necessitates the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." 1975 Ala. Code § 26–23G–2(6). The State argues that the health exception would kick in in the situation in which a fetal-demise procedure fails and poses a significant health risk to the patient. In particular, the State argues that whenever cord transection fails, then the health exception would apply, and that in some of the cases where digoxin or potassium-chloride injections fail, the health exception might apply.

The State's arguments are not convincing. First, the existence of a health exception does not address the fact that no training is available for technically difficult procedures like potassium-chloride injections and cord transection, or that no data are available on the appropriate dosage, timing, and risks of digoxin for women between 15 and 18 weeks of pregnancy, or for a second dose of digoxin should the first dose fail. Second, because the fetal-demise procedures themselves impose significant health risks (and therefore the State cannot constitutionally require them under *Gonzales*), a health exception to address those health risks cannot alter the fact that such procedures are not constitutional: a medical exception cannot save an otherwise unconstitutional ban. *See Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323, 340 (6th Cir. 2007) (holding that a general ban on standard D & E imposed an undue burden and that "it is unnecessary ... to address exceptions to an unconstitutional and unenforceable general rule").

Third, counsel's assertion as to how the health exception would be construed are not determinative of how the exception would actually be enforced. *See Stenberg*, 530 U.S. at 941, 120 S.Ct. 2597 (rejecting the Attorney General's interpretation of the statute and warning against accepting as authoritative an Attorney General's litigation position when it does not bind state courts or local law enforcement authorities); 1975 Ala. Code § 12–17–184 (showing that district attorneys have independent authority to prosecute "all indictable offenses"). In fact, evidence suggests that the health exception, as written, will not operate in the way that the State's counsel described, given the history and usage of such exceptions in other abortion regulation contexts in Alabama. *See, e.g.*, Report of Induced Termination of Pregnancy, ADPH–HS–10 (doc. no. 89–2) at 7. Alabama prohibits abortion at or after 22 weeks unless a health exception can be invoked; this health exception's language is identical to the one included in the fetal-demise law. According to hearing testimony and the State administrative form for reporting abortions, the Alabama Department of Public Health has interpreted this language to require actual serious and

life-threatening conditions such as "severe preeclampsia" or "life threatening sepsis," rather than the *risks* of developing such conditions. Tr. Vol. II (doc. no. 111) at 148:1–16. In other words, the plaintiffs would have to wait until their patients are in extremely serious danger before they could safely invoke the health exception and proceed to performing a D & E with first inducing fetal demise.

Even the plain language of the exception makes it evident that it sets an extremely high threshold: the exception would not apply unless there is a "*serious* risk of *substantial* and *irreversible* physical impairment of a *major* bodily function." 1975 Ala. Code § 26–23G–2(6) (emphasis added). The words "serious risk" and "substantial" set the bar high; the word "irreversible" raises the bar to another level entirely. The applicability of the health exception, by its terms, turns on whether there is a serious risk of substantial, permanent disability. The physician could not invoke the health exception where the patient, while at serious risk of grave illness, would likely recover from the illness eventually, no matter how long that recovery would take. Take, for example, a patient undergoing serious blood loss during an unsuccessful attempt at umbilical-cord transection: if the physician assessed that patient as being in a serious risk of being bedridden for six months as a result of that blood loss, but thought that she would probably recover without permanent disability, the health exception would not apply. Due to its extremely limited application, the health exception provides vanishingly little protection for patients or doctors.

***30** Most significantly, the exception would not protect against the grave health risks arising from cord transection because the procedure does not 'fail' at a discrete point that would trigger the health exception. The blood loss accompanying the cord transection procedure happens on a continuum: the longer the transection procedure takes, the greater the risk of serious blood loss becomes. Therefore, in order to trigger the health exception, the physician would have to make a difficult snap judgment on the murky issue of whether the blood loss has reached a level at which the health exception can be safely triggered and the physician can stop blindly attempting to transect the cord and proceed to standard D & E. To be sure, the statute's health exception is governed by a reasonableness standard; however, here that reasonableness would be determined post-hoc in a proceeding in which the physician would face criminal prosecution, in a State in which these physicians are already working in a hostile climate.

The fetal-demise law also burdens Alabama women by reducing the number of doctors in Alabama able and willing to perform abortions. First, not all residency programs train doctors in standard D & E, so finding doctors trained in abortion care and willing to practice in Alabama proves difficult for abortion providers. *Practice Bulletin: Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1395 (2013) ("Dilation and evacuation training is not available in all residency programs, and many residents trained in D & E have not performed a sufficient number of procedures to achieve competency in the technique.") The fetal-demise requirement tacks on an additional training requirement—training that is not readily available to Alabama doctors—on the already few doctors trained in standard D & E in Alabama. Second, the fetal-demise law would increase the difficulty of finding doctors to work in Alabama because it imposes a requirement that doctors could view as compromising their ethical obligations to patients. The medical directors of both clinics testified as to having difficulty finding doctors trained and willing to provide abortion services; they further testified that, if forced to induce fetal-demise before every D & E, they would stop performing second-trimester abortions in order to comply with their ethical obligation of beneficence—doing what is in the best interest of patients. Second Parker Decl. (doc. no. 54–6) ¶ 16; Robinson White Decl. (doc. no. 54–4) ¶ 25. While the State argues it cannot be held responsible if doctors elect not to perform abortions under the new regulations, the court disagrees. The law imposes an affirmative obligation on doctors to perform an unsafe procedure —with no medical benefit to the patient—for which they are not trained.[37] Doctors are subject to liability for violations of ethical duties,[38] and these doctors believe—in part based on guidance from the American College of Obstetricians and Gynecologists, as well as the Society of Family Planning—that administering a risky, experimental procedure for which they are not trained that delivers no benefit to the patients violates that code of ethics. *See* Davis Decl. (doc. no. 54–5) ¶ 18–19. The court cannot find these doctors to be unreasonable for refusing to expose themselves to liability, in addition to the harassment and abuse they already face as doctors practicing abortions in Alabama. Further, given the ethical concerns and the climate of hostility doctors face, combined with the testimony of both clinic

directors demonstrating the difficulty of finding doctors trained and willing to perform abortions in Alabama, this ethical hurdle will likely further dissuade other doctors from coming to the State to take the place of the current doctors. While these considerations alone may not constitute an undue burden, together with the other findings by the court, they further contribute to the court's conclusion that the fetal-demise law would impose a significant obstacle to abortion access at and after 15 weeks of pregnancy.

* * *

***31** As stated above, to determine whether a law regulating abortion constitutes an undue burden on the right to terminate a pregnancy before viability, the court must consider the State's interests underlying a law in conjunction with the obstacles imposed by the law to women's access to abortion under the *Casey* undue-burden test.

While the court assumes the State's interests are legitimate, it is clear that the State cannot pursue its interests in a way that completely denies women the constitutionally protected right to terminate a pregnancy before the fetus is viable: as important as the State's professed interests in the dignity of the fetal life and the regulation of the medical profession, those interests cannot be considered in isolation; they must be considered in the context of women's right to elect a pre-viability abortion, and that right must remain free of undue state interference and substantial obstacles regardless of the legitimacy of state interests. *Casey*, 505 U.S. at 846, 112 S.Ct. 2791. Indeed, the State does not contend that the fetal-demise law can stand in the absence of alternative procedures.

Here, the State contends that its interests are sufficiently strong to justify the burdens the fetal-demise law would impose on Alabama women because they would retain the ability to terminate pregnancy at or after 15 weeks. The State's argument is premised on the idea that it is feasible for the only clinics that provide elective abortions starting at 15 weeks of pregnancy to utilize the three fetal-demise methods before performing the most common second-trimester abortion method. However, for the reasons discussed above, the court concludes that the proposed fetal-demise methods are not feasible for inducing fetal demise before standard D & E at the Alabama clinics. Therefore, if the court were to allow the fetal-demise law to go into effect, Alabama women would likely lose their right to pre-viability abortion access at or after 15 weeks. The State's interests, although legitimate, are not sufficient to justify such a substantial obstacle to the constitutionally protected right to terminate a pregnancy before viability.

Because the State's interests are insufficient to overcome the denial of Alabama women's right to terminate a pre-viability pregnancy at or after 15 weeks, and because the fetal-demise law would place substantial, and even insurmountable, obstacles before Alabama women seeking pre-viability abortions, the court concludes that the law constitutes an undue burden on abortion access and is unconstitutional.

VII. GONZALES

In briefs filed before the hearing as well as in the briefs filed after the preliminary injunction was entered, the State argued extensively that this case is controlled by *Gonzales v. Carhart*, 550 U.S. 124, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007), which upheld a federal law banning the use of the intact D & E abortion procedure against a broad facial challenge; and that under *Gonzales*, the plaintiffs are not entitled to relief. On the contrary, the court's holding today is fully in keeping with *Gonzales*. In upholding the ban on intact D & E, the *Gonzales* Court first concluded that the ban did not prohibit the most common procedure for second-trimester abortions, standard D & E, and then analyzed whether the procedure that would remain legal would in some circumstances pose more risk to the health of the woman than the prohibited procedure of intact D & E. Because the most common procedure—standard D & E—would remain an available and viable option for all women, and expert testimony conflicted as to whether the rarely used procedure, intact D & E, was ever safer, the Court found that the ban did not create a substantial obstacle to obtaining an abortion. In other words, because "there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health, given the availability of other abortion procedures that are considered to be safe alternatives," the Court upheld that ban on intact D & E. *Id.* at 166–67, 127 S.Ct. 1610. While *Gonzales* thus found that legislative factual findings were due some deference amidst circumstances of "medical uncertainty," the Court also noted that courts "retain[ ] an independent constitutional duty to review factual findings

where constitutional rights are stake." *Id.* at 165, 127 S.Ct. 1610. Consequently, the Court's deference to the legislature was not "uncritical," and legislative findings were not given "dispositive weight." *Id.* at 165–66, 127 S.Ct. 1610.

***32** With regard to the fetal-demise law, the State argues that under *Gonzales*, any time there is medical uncertainty about whether a procedure is safe or even when there are unknown risks of an experimental procedure, the legislature can further the State's interest in promoting respect for fetal life by requiring physicians to use that medical procedure to perform an abortion. The court disagrees, for several reasons.

First, the Court in *Whole Woman's Health* squarely rejected a reading of *Gonzales*—and of the Court's abortion jurisprudence more broadly—as suggesting that "that legislatures, and not courts, must resolve questions of medical uncertainty." *Whole Woman's Health*, 136 S.Ct. at 2310. The Court further contrasted the undue-burden standard with the Court's less searching review of economic legislation under *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955). *Id.* at 2309–10. "Instead, the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings." *Id.* at 2310 (discussing *Casey*, 505 U.S. at 888–94, 112 S.Ct. 2791, and *Gonzales*, 550 U.S. at 165–66, 127 S.Ct. 1610). Accordingly, district courts reviewing challenged abortion regulations must "consider[ ] the evidence in the record —including expert evidence, presented in stipulations, depositions, and testimony[,] [and] then weigh[ ] the asserted benefits against the burdens." *Id.*; *see also id.* at 2324 (Thomas, J., dissenting) ("[T]oday's opinion tells the courts that, when the law's justifications are medically uncertain, they need not defer to the legislature, and must instead assess medical justifications for abortion restrictions by scrutinizing the record themselves.").

In *Whole Woman's Health*, the Court noted, "Unlike in *Gonzales*, the relevant statute here does not set forth any legislative findings." 136 S.Ct. at 2310. In the absence of such findings, the district court there was "left to infer that the legislature sought to further a constitutionally acceptable objective" and to "give significant weight to evidence in the judicial record." *Id.* Similarly, here, neither the school-proximity law nor the fetal-demise law contained legislative findings. Specifically, the fetal-demise law contained no findings as to the safety of alternative abortion methods, including the three alternatives—umbilical-cord transection, potassium-chloride injection, and digoxin injection—proposed by the State in this litigation, and there is no other evidence that these alternatives have been subject to scrutiny through the legislative fact-finding process. Moreover, there is no indication that the Alabama legislature relied on the safety of these alternatives in drafting the fetal-demise law. Without such findings, the court accordingly "consider[s] the evidence in the record—including expert evidence," and "give[s] significant weight" to that evidence. *Id.* at 2310. The court concludes on that basis that both the school-proximity law and the fetal-demise law, "while furthering a valid state interest, ha[ve] the effect of placing a substantial obstacle in the path of a woman's choice [to have an abortion of a nonviable fetus," and are therefore unconstitutional. *Id.* at 2309 (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)).

In addition, the Court in *Gonzales* addressed a statute that banned a rarely used abortion method, intact D & E. 550 U.S. at 155, 127 S.Ct. 1610 (noting that intact D & E constitutes "a small fraction of the overall number of D & E abortions"). In finding that the ban did not create a substantial obstacle, the Court relied heavily on the fact that the most common procedure—standard D & E—would remain available to all women under the statute. *Id.* at 150–54, 166–67, 127 S.Ct. 1610 (noting "the availability of other abortion procedures that are considered to be safe alternatives"); *cf. Stenberg*, 530 U.S. at 945–46, 120 S.Ct. 2597 (holding Nebraska ban on intact D & E unconstitutional because it was broad enough to allow prosecution of "physicians who use [standard] D & E procedures, the most commonly used method for performing pre-viability second trimester abortions"). By contrast, the Alabama fetal-demise law has the effect of rendering the most common second-trimester abortion method, standard D & E, unavailable to women in Alabama. Indeed, this is precisely the method that *Gonzales* took care to note remained available. Because *Gonzales* dealt with a ban on one exceedingly rare form of abortion, it cannot be read to suggest that statutes that effectively ban common abortion methods—such as the fetal-demise law—should be upheld.

*33 To the extent the State contends, relying on *Gonzales*, that a court should wait until the laws are in effect before determining whether they have imposed an undue burden warranting facial relief, this court disagrees. This 'wait-and-see' approach would require the court to wait—until the clinics close, until the doctors are prosecuted, until women in Alabama cannot access abortion—before holding an abortion regulation to be facially invalid. By this time, however, the damage will have been done. In addition to the interim harm to particular women's constitutional rights to access a pre-viability abortion—a harm that cannot be undone once denied—the long-term viability of that right in the State may have been irreversibly compromised: doctors may not return to their practices; as the court's findings demonstrate, the plaintiff clinics—already in financial peril—are not likely to reopen. The court finds nothing in the Supreme Court's jurisprudence that requires courts to witness the deterioration of a constitutional right before acting to protect it.

Moreover, it is notable that the law at issue in *Gonzales* was a federal statute that imposed a nationwide ban, in contrast to the two Alabama statutes challenged here. *Gonzales* rejected the plaintiffs' "broad, facial attack" against that statute, and found that an as-applied challenge based on particular factual circumstances would have been more appropriate under the circumstances. 550 U.S. at 133, 167–68, 127 S.Ct. 1610. As this court has observed, *Casey*'s undue-burden standard requires a "real-world analysis" of an abortion regulation's effects, *Planned Parenthood Se.*, 172 F.Supp.3d at 1289, including such relevant factors as "the nature and circumstances of the women affected by the regulation, the availability of abortion services, both prior to and under the challenged regulation, ... and the social, cultural, and political context." *Planned Parenthood Se.*, 33 F.Supp.3d at 1342; *cf. Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 915 (9th Cir. 2014) (Fletcher, J.) (describing relevant factors to burdens analysis as including "the ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations"); *Planned Parenthood v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013), *cert. denied*, —— U.S. ——, 134 S.Ct. 2841, 189 L.Ed.2d 807 (2014) ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered."). In other words, the undue-burden analysis focuses on factors that can vary greatly between jurisdictions; a regulation that places a substantial obstacle to women in one jurisdiction, based on a number of these factors, may not pose such an obstacle in another jurisdiction where those factors do not exist.[39] *Gonzales*'s reluctance to entertain a broad challenge to a statute of nationwide application, in light of the jurisdiction-specific factors that may inform the undue-burden analysis, does not dissuade this court from holding that the Alabama laws challenged here create a substantial obstacle to women seeking pre-viability abortions in Alabama.

VIII. SCOPE OF RELIEF

Finally, the court concludes that the school-proximity law is unconstitutional both as applied to the plaintiffs and facially and that the fetal-demise law is unconstitutional as applied to the plaintiffs.[40]

[19] A law restricting abortion is facially unconstitutional if, "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791; *accord Whole Woman's Health*, 136 S.Ct. at 2320; *see also Reproductive Health Servs. v. Strange*, 204 F.Supp.3d 1300, 1332–34 (M.D. Ala. 2016) (Walker, M.J.) (concluding that *Whole Woman's Health* confirmed that *Casey*'s large-fraction test applies to facial challenges to a statute regulating abortion). In the large-fraction test, one must use as the denominator those cases "in which the provision at issue is relevant," which is a narrower class than "pregnant women" or "the class of women seeking abortions." *Whole Woman's Health*, 136 S.Ct. at 2320 (citing *Casey*, 505 U.S. at 894–95, 112 S.Ct. 2791) (internal quotations and alterations omitted).

*34 The plaintiffs have amply demonstrated that the school-proximity law is unconstitutional as applied to them because the law imposes a substantial obstacle to women seeking access to abortions at the plaintiff clinics. Whereas abortion in Tuscaloosa, Huntsville, and the surrounding areas is currently relatively accessible, the law would result in the closure of the clinics and therefore eliminate the availability of abortion in Alabama at or after 15 weeks. Women at an earlier stage of their pregnancies would be required to travel long distances to obtain abortion care. Nor would these women be assured of the opportunity to obtain a timely abortion elsewhere, and some women would not be able to receive an abortion

at all due to the delay or added travel time and costs. In contrast, the State has presented minimal evidence that requiring the existing clinics to relocate would further its asserted interests. As such, the plaintiff clinics have demonstrated that their substantive due process claim should prevail.

In addition, the school-proximity law is facially unconstitutional. As explained above, a law restricting abortion is facially unconstitutional if, "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 888–95, 112 S.Ct. 2791. During argument on the motion for preliminary injunction, the plaintiffs contended that the fraction's denominator—the class of women for whom the school-proximity law would be relevant—should be all women who would have sought abortion care at the Huntsville and Tuscaloosa clinics. In contrast, the State argued that the denominator should be all women who receive abortion care at clinics throughout the State. Under the plaintiffs' reading, practically all women who would have sought abortions in Huntsville and Tuscaloosa would be burdened by those clinics' closure. But even under the State's approach, a large fraction of women in Alabama would experience a substantial obstacle because so many have relied on the Huntsville and Tuscaloosa clinics. Indeed, the majority of women who receive abortions in Alabama do so at the plaintiff clinics—and for the most recent year for which complete statistics are available, 70 % of women who obtained abortions in Alabama received them at one of those locations. And of course, all Alabama women seeking abortion at or after 15 weeks would experience a substantial obstacle, as the only clinics they could have used would be closed. Thus, using either denominator, the court concludes that the school-proximity law will operate as a substantial obstacle, if not an absolute barrier, to a large fraction of the women for whom the law is relevant.

Beyond the closure of the plaintiff clinics as a result of the school-proximity law, all abortion clinics in Alabama would suddenly find themselves under threat of closure, dependent on the mercy of local zoning boards and school districts making school construction decisions. The law prohibits the Health Department from renewing the license of any abortion clinic located within 2,000 feet of a K–8 school; it makes no exception if a school is later built near a pre-existing clinic. For example, if a K–8 public school were built within 2,000 feet of the Mobile abortion clinic on December 1, 2017, then that clinic too would be required to move or close at the year-end expiration of its license; given the difficulty of siting new clinics in Alabama's climate of hostility to abortion, the exclusion of areas within 2,000 feet of public K–8 schools, the extensive surgical-center requirements for buildings where Alabama abortion clinics operate, and the financial circumstances of any particular clinic, closure would be a significant risk.[41] This ever-present possibility would threaten the right of all women in Alabama to access an abortion.

***35** Accordingly, the court holds that school-proximity law unconstitutional both facially and as applied to the plaintiffs.

Turning to the fetal-demise law, the parties agree that the plaintiffs brought a facial challenge to that statute. However, as the Supreme Court observed that in *Whole Woman's Health*, a "final judgment should grant the relief to which each party is entitled, even if the party has not demanded that relief in its pleadings." 136 S.Ct. at 2307 (quoting Fed. R. Civ. P. 54(c)). Accordingly, although the plaintiffs there had brought an as-applied challenge as to the Texas statute's admitting-privileges requirement, because "the arguments and evidence show[ed] that [the] statutory provision [was] unconstitutional on its face," the Court upheld the district court's grant of facial relief on that claim.[42] *Id.*

The question of as-applied and facial relief is admittedly complex with regard to the fetal-demise law. The parties disagree as to the appropriate test for when facial relief may be granted. While the court finds unconvincing the State's argument that *Gonzales* sets a new test for facial relief that replaces *Casey* 's significant-fraction test, it need not decide the issue. As discussed above, the parties' arguments and evidence clearly demonstrate that the fetal-demise law places an undue burden on women seeking a pre-viability abortion at the Huntsville and Tuscaloosa clinics. Because there is no question that the fetal-demise law is unconstitutional as applied to the plaintiffs, and because the court can provide sufficient relief with an as-applied finding at this time, the court in its discretion grants only as-applied relief on the fetal-demise law.

Finally, the court, as it did with the preliminary injunction order, does not extend the final injunction to

the private civil-enforcement provisions under the fetal-demise law. [43]

* * *

In summary, "a statute which, while furthering a valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Whole Woman's Health*, 136 S.Ct. at 2309 (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)). At issue here is whether Alabama can pass a school-proximity law whose effect is to shut down the Huntsville and Tuscaloosa clinics. Similarly, the question for the fetal-demise law is whether the court can let stand a statute whose effect will unquestionably be to prevent women in Alabama from obtaining an abortion after 15 weeks. The answer to both questions is no.

***36** The court will, therefore, enter an order enjoining enforcement of the school-proximity and fetal-demise laws.

DONE, this 26th day of October, 2017.

All Citations

--- F.Supp.3d ----, 2017 WL 4843230

Footnotes

1 Throughout the remainder of this opinion, the week of pregnancy refers to gestational age as measured from the last menstrual period (LMP), which is two weeks longer than the post-fertilization age. The court has adjusted the numbers accordingly when citing statistics based on post-fertilization age.

2 In addition to abortion clinics, a very small number of abortions take place in Alabama hospitals and physician offices. In 2014, 8,080 abortions were performed in Alabama; of those, 23 abortions were performed in hospitals and six abortions were provided at physician offices. Second Johnson Decl. Ex. D (doc. no. 54–2) at 35.

3 The three other clinics operating in Alabama are Reproductive Health Services in Montgomery and Planned Parenthood clinics in Birmingham and Mobile.

4 Statistics are derived from 2010 census data. *See* U.S. Census Bureau, 2010 Census Population and Housing Tables, https://www.census.gov/population/www/cen2010/cph-t/CPH-T-5.pdf.

5 The Court in *Whole Woman's Health* contrasted the undue-burden standard to the Court's less searching review of economic legislation under the rational-basis standard, and specifically rejected the notion "that legislatures, and not courts, must resolve questions of medical uncertainty." *Whole Woman's Health*, 136 S.Ct. at 2309–10 (citing *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955)). Unlike with rational-basis review, "the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings." *Id.* at 2310 (emphasis added) (citing *Casey*, 505 U.S. at 888–94, 112 S.Ct. 2791, and *Gonzales*, 550 U.S. at 165–66, 127 S.Ct. 1610).

6 Counsel for the State agreed that nothing in the record indicates the legislature intentionally included the Tuscaloosa clinic within the scope of the school-proximity law. Tr. Vol. III (doc. no. 112) at 15:9–11.

7 As evidence, the State relies on newspaper articles which describe complaints from a few Academy parents about anti-abortion protesters outside the Huntsville clinic, including objections that the protesters appeared to target the parents and concern about traffic safety and delay. Newspaper Articles, Def. Ex. 16 (doc. no. 81–16), Def. Ex. 17 (doc. no. 81–17), & Def. Ex. 18 (doc. no. 81–18).

8 Robinson White would continue to perform up to 100 abortions per year at the location of the Huntsville clinic, the maximum number permitted under Alabama law without an abortion clinic license. Robinson White Decl. (doc. no. 54–4) ¶ 16.

9 Moreover, although the court does not reach this issue, the fact that the school-proximity law may do little or nothing for the stated purpose suggests that the law's actual purpose may have been "to place a substantial obstacle in the path of a woman seeking an abortion," and that the law would therefore fail the undue-burden test independent of its effects. *See Whole Woman's Health*, 136 S.Ct. at 2300 (quoting *Casey*, 505 U.S. at 878, 112 S.Ct. 2791 (plurality)). Legislative purpose may be inferred from the extent to which the statute actually furthers, or fails to further, the purported state interests. Thus, "without evidence that the curtailment [of the right to an abortion] is justifiable by reference to the benefits conferred by the statute," it can be inferred that the legislature may hold an improper purpose, passing measures

that "may do little or nothing for [the stated purpose], but rather strew impediments to abortion." *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 921 (7th Cir. 2015) (Posner, J.); *cf. Snyder v. Louisiana*, 552 U.S. 472, 484–85, 128 S.Ct. 1203, 170 L.Ed.2d 175 (noting with regard to a *Batson* claim that a court's finding that a proffered reason was pretextual "naturally gives rise to an inference" of an impermissible purpose); *St. Mary's Honor Ctr. v. Hicks*, 509 U.S. 502, 511, 113 S.Ct. 2742, 125 L.Ed.2d 407 (1993) (holding, under Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 1981a and 2000e through 2000e–17), that the rejection of an employer's proffered reason for a given action permits the trier of fact to infer an improper discriminatory purpose). The court's finding that the school-proximity law will provide little to no benefit to the State's purported interests therefore raises the question of whether the law in fact had the impermissible purpose of placing a substantial obstacle to women's access to abortion.

10 The State has not disputed any of the plaintiffs' evidence about the resulting burdens on women should the Huntsville and Tuscaloosa clinics be forced to close.

11 Admittedly, to obtain an abortion at that point, women in Huntsville and Tuscaloosa could travel approximately 400 miles round-trip out of state to the nearest provider in Atlanta. Second Henshaw Decl. (doc. no. 54–3) ¶¶ 18, 20. For women relying on public transportation, that would require a round trip of at least 12 hours in duration. Katz Decl. (doc. no. 54–11) ¶ 21. Citing a study from a similar scenario in Texas, Dr. Stanley Henshaw concluded that the effect in Alabama would be comparable to a 70 % reduction in the number of Alabama women who obtained abortions starting at approximately 15 weeks of pregnancy. Second Henshaw Decl. (doc. no. 54–3) ¶ 20. In 2014, 560 abortion procedures were performed beginning at 15 weeks. *See* Donald Decl. Ex. F, Induced Terminations of Pregnancy Occurring in Alabama, 2014 (doc. no. 81–14). Moreover, although some women in Alabama could continue to access abortions beginning at 15 weeks by traveling out of state, courts have refused to allow out-of-jurisdiction access to cure within-jurisdiction restrictions. See *Planned Parenthood Se.*, 33 F.Supp.3d at 1360–61; *see also Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 918 (7th Cir. 2015) (Posner, J.) (rejecting argument that the availability of late second-trimester abortions in Chicago could justify the closure of Wisconsin's only abortion clinic that conducted such abortions, because "the proposition that the harm to a constitutional right can be measured by the extent to which it can be exercised in another jurisdiction is a profoundly mistaken assumption." (internal quotation marks, citations, and alterations omitted)); *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014) (holding that the undue-burden analysis "focuses solely on the effects within the regulating state," and that a Mississippi abortion law therefore placed an undue burden); *cf. Missouri ex rel. Gaines v. Canada*, 305 U.S. 337, 350–51, 59 S.Ct. 232, 83 L.Ed. 208 (1938) (rejecting as "beside the point" the argument that black law students refused admission at the State University of Missouri could simply attend nearby law schools in other States, because the requirement of Equal Protection "is imposed by the Constitution upon the States severally" and "cannot be cast by one State upon another"). Nonetheless, the court does not need to resolve the legal issue of whether to consider out-of-state clinics because, even if this court were to consider those clinics, it would reach the same conclusion.

12 While Alabama law allows the informed consent counseling to be conducted either in person or by restricted delivery mail, restricted delivery is not a feasible option for low-income patients for a number of reasons. First, mail in low-income communities is "notoriously unreliable." Sheila Katz Tr. (doc. no. 90–2) at 30:17. Second, restricted mail requires the addressee sign for the mail upon delivery, and many low-income women work during the day and would therefore be unable to sign for it. Third, whereas middle- and upper-class women may be able to get mail delivered to their work, low-income women often do not work in occupations where this is an option, and even when possible, doing so would risk compromising the confidentiality of the correspondence, which is important for all women but is particularly important for women in abusive relationships.

13 This phrase, French in etymology, means "for lack of an alternative." *Faute de mieux*, Oxford English Dictionary (2d ed. 1989).

14 Incidentally, women in the South have resorted to turpentine before. One study from 1936 reported that rural black women in Georgia consumed turpentine for self-induced abortions. Turpentine relies on ingredients similar to those reportedly used by southern slaves seeking to self-abort. Jessie M. Rodrique, *The Black Community and the Birth Control Movement*, in *Women and Health in America* 293, 295 (Judith Walzer Leavitt ed., 1999).

15 Even if the clinics did not permanently close, the temporary closure of both clinics would still impose the significant burdens described above on women seeking abortions in Alabama until each clinic could secure a new facility.

16 While the court finds that the State's justifications for the school-proximity law are weak, the court must emphasize that its conclusion does not turn solely on that finding. In the alternative, the court further finds that the justifications are by no means sufficiently strong to justify the obstacles that the requirement would impose on women seeking an abortion.

17 The law does not use or define the term 'fetal demise' or explain how fetal demise should be determined. The parties appear to agree that the fetus would no longer be considered "living" under the law when asystole, or the termination of a heartbeat, occurs, and they used the term 'fetal demise' to denote that occurrence. The court likewise uses the term to mean termination of the fetal heartbeat.

18 It is worth noting that the State does not argue that the ban on dismemberment abortion is designed to avoid fetal pain. Fetal pain is not a biological possibility until 29 weeks, well beyond the range of standard D & E procedures and beyond the legal limit of abortion in Alabama; the State does not dispute this. Tr. Vol. I (doc. no. 110) at 138:1–6.

19 The court uses the term 'standard D & E' in order to distinguish it from 'intact D & E,' sometimes called 'D&X,' which involves dilating the cervix enough to remove the whole fetus intact. 'Intact D & E' is banned under the federal Partial–Birth Abortion Ban Act of 2003, unless fetal demise is induced before the procedure. *See Gonzales v. Carhart*, 550 U.S. 124, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007) (upholding the federal partial-birth abortion ban).

20 Occasionally, a physician may determine that a more gradual dilation is in the best interest of the patient and will begin dilation the day prior to the procedure. Second Parker Decl. (doc. no. 54–6) ¶ 13 ("I perform the vast majority of D & E's at WAWC as a one-day procedure. However, there are some women for whom I wish to achieve a more gradual and/or wider dilation of the cervix, in which case I will administer osmotic dilators to begin cervical ripening the day before the procedure.").

21 Exhibits C and F provide the number of abortions in Alabama as reported to the Alabama Department of Public Health. After these exhibits were submitted, the plaintiffs brought to the court's attention that there had been a clerical error in the reporting of standard D & E procedures. To rectify this error, the plaintiffs submitted supplemental declarations and exhibits correcting the number of such procedures performed from 2012–2015. *See* Second Robinson White Decl. (doc. no. 89–1); Third Gray Decl. (doc. no. 89–2); WAWC Summary of Abortions Performed, Pls.' Ex. 16; AWC Summary of Abortions Performed, Pls.' Ex. 17. The defendants did not object to these corrected figures.

22 The induction method involves using medication to induce labor and deliver a non-viable fetus over the course of hours or even days. Tr. Vol. I (doc. no. 110) at 12:20–13:30. Induction procedures are more expensive, difficult, and stressful for the patient. State regulations do not allow outpatient clinics to initiate an abortion procedure that may entail more than 12 hours of clinical involvement, which means that induction abortion must be performed in a hospital. Tr. Vol. II (doc. no. 111) at 43:8–24. The State does not dispute that induction procedures are unavailable to women seeking second-trimester abortions in outpatient clinics in Alabama. *See supra* note 1.

23 Because the vast majority of patients in Alabama who receive standard D & E have the procedure between 15 and 18 weeks of pregnancy, the cord is quite narrow in the majority of such procedures. *See* Donald Decl. Ex. C, Induced Terminations of Pregnancy Occurring in Ala. (doc. no. 81–14) (providing that 80 % of women who received standard D & E in 2014 did so between 15 and 18 weeks LMP or 13 to 16 post-fertilization age).

24 The State argues that the law's health exception would apply were a physician to attempt to transect the umbilical cord and fail, because the patient would then be in serious risk of irreversible impairment to major bodily functions. This argument, along with the general discussion of the health exception, is addressed later in this section.

25 Of course, some people *choose* to undergo risky, or even experimental, procedures when they foresee some possibility of medical benefit; no one goes to the doctor and elects to have an experimental procedure that only increases the risk of complications and pain and confers no medical benefit even in the best-case scenario. The question at hand is whether a State can *mandate* a woman to undergo an experimental procedure that is more likely to harm her compared to the standard abortion procedure.

26 If the physician misses the fetal heart, potassium chloride may still be injected into the fetal body compartment. However, injecting outside of the heart may require a larger volume or a longer time to achieve fetal demise. Tr. Vol. II (doc. no. 111) at 120: 9–16; Biggio Decl. (doc. no. 81–1) ¶ 7.

27 As explained above, fetal reduction refers to a procedure where one or more of the fetuses in the same pregnancy are terminated and the rest are carried to full-term, due to health risks of multiple gestations.

28 For the reasons discussed in the subsection below about the parties' experts, the court rejected the State's expert's far lower estimate of the number of procedures the clinic doctors would need to view in order to be able to perform the procedure safely. In any case, even if he were correct, there would be no practical way for them to observe those procedures.

29 It is unlikely that Alabama will attract new providers who are already trained in these procedures, as Alabama has proven to be a hostile environment for abortion providers. *See Planned Parenthood Southeast, Inc. v. Strange*, 33 F.Supp.3d at 1333–34 (describing history of violence against abortion providers and decline in the number of clinics in Alabama in recent years).

30 Amniocentesis is a testing procedure used in high-risk pregnancies, whereby a needle is used to extract amniotic fluid from the uterus. The State argued that the risks associated with digoxin injection are comparable to this procedure. In addition to the undisputed fact that digoxin injection is riskier than amniocentesis, the analogy fails: amniocentesis is a procedure that only a small subset of women—those with high-risk pregnancies—*elect* to undergo in order to obtain vital information about the health of the fetus. In contrast, the digoxin injection (or other fetal-demise method) would be State-mandated for *all* women, would provide no benefit to the patient, and would not be in any sense medically necessary.

31 This complication would have even worse consequences for women surrounded by people who do not support their decision to terminate a pregnancy, or if they have abusive partners who find out about the abortion due to a medical emergency caused by extramural delivery. Tr. Vol. I (doc. no. 110) at 72:1–13; *see also Casey*, 505 U.S. at 887–98, 112 S.Ct. 2791 (majority opinion) (striking down the spousal-notification requirement based on concerns about abused women seeking abortion).

32 The State argued that these fetal-demise procedures do not introduce new categories of risks that are not already present in standard D & E. *See, e.g.*, Tr. Vol. II (doc. no. 111) at 13:15–22. However, the significant risk of spontaneous labor and extramural delivery associated with digoxin does not apply to standard D & E. Tr. Vol. II (doc. no. 111) at 150:2–6. This means that digoxin injection introduces a new category of significant risk into second-trimester abortion procedures. More to the point, *Casey* simply asks whether the law imposes "significant health risks" on women, rather than asking whether an alternative procedure introduces new types of risks. *Casey*, 505 U.S. at 880, 112 S.Ct. 2791.

33 The court notes that 25.2 % of Tuscaloosa's population lives below the poverty line, as do 17.6 % of Huntsville residents. Katz Decl. (doc. no. 54–11) ¶ 8.

34 The medical director of the Huntsville clinic also described the difficulties that her patients face with arranging child care, traveling far distances to the clinic, and affording shelter during the trip. For example, some women who are unable to afford staying at a hotel sleep in the parking lot of the clinic. Tr. Vol. I (doc. no. 110) at 207:9–11.

35 Dr. Robinson White credibly testified that because at least 88 % of women live in a county with no abortion provider, women travel from as far as Mobile—which is about five hours away by car—to the Huntsville clinic. Tr. Vol. I (doc. no. 110) at 207:8–9; *see also* Tr. Vol. I (doc. no. 110) at 203:8–13 (describing how the fetal-demise requirement would increase the number of trips a woman seeking an abortion would have to make from two to three or four); Tr. Vol. II (doc. no. 111) at 37: 21—38:5 (explaining that women travel to the Huntsville clinic from west Alabama and southern Alabama). Patients traveling these great distances would either have to make at least three lengthy round trips to the clinic over a four-day period, or travel and stay in the area over the four days. Either option would require the patient to take a number of days off work, including an additional day in the event that she would need to leave the day before to make it to the appointment.

36 Twenty-two weeks after the last menstrual cycle is the latest point at which Alabama allows abortions, unless a health exception can be invoked. 1975 Ala. Code § 26–23B–5.

37 This is not a matter of giving doctors "unfettered choice" in abortion procedures. *Gonzales*, 550 U.S. at 163, 127 S.Ct. 1610. As the evidence demonstrated, the fetal-demise law offers doctors no "reasonable alternative procedures." *Id.* Here, doctors are required to take an affirmative adverse action against patients by performing one of the three risky fetal-demise methods, or not performing the abortion at all.

38 Douglas NeJaime & Reva Siegel, *Conscience Wars: Complicity–Based Conscience Claims in Religion and Politics*, 124 Yale L.J. 2516, 2534 ("Licensing boards enforce professional standards against healthcare institutions, doctors, nurses and pharmacists. Tort law, and specifically medical malpractice, provides redress to patients injured by breaches of professional duties.").

39 Indeed, the court does not reach whether Alabama's fetal-demise law might be constitutional in another jurisdiction where different conditions exist, such as where abortions are routinely available in specialized hospitals.

40 This court has previously discussed the law on facial versus as-applied relief in another abortion context. *See Planned Parenthood Se., Inc. v. Strange*, 172 F.Supp.3d 1275, 1284 (M.D. Ala. 2016) (Thompson, J.).

41 The school-proximity law operates in conjunction with the surgical-center requirements law to limit the locations where abortion clinics can be located and to increase the expense of operating such clinics; the combined impact of these laws contribute to the undue burden on the right of women in Alabama to access a pre-viability abortion. *See Planned Parenthood v. Van Hollen*, 738 F.3d 786, 798–99 (7th Cir. 2013), *cert. denied*, —— U.S. ——, 134 S.Ct. 2841, 189 L.Ed.2d 807 (2014) (Posner, J.) ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered.").

42 The Court further noted that the petitioners had, "in addition to asking for as-applied relief, ... asked for 'such other and further relief as the Court may deem just, proper, and equitable.' *Whole Woman's Health*, 136 S.Ct. at 2307. Here

likewise, the plaintiffs requested that the court grant "such other, further, and different relief as the Court may deem just and proper." First Supplemental Compl. (doc. no. 50) at 31.

43 The parties did not object when the court did so in the preliminary-injunction order. There, the court noted *sua sponte* that the Eleventh Amendment bars relief against an allegedly unconstitutional provision if the named State officials do not have the authority to enforce it. *Summit Med. Assocs., P.C. v. Pryor*, 180 F.3d 1326 (11th Cir. 1999).

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2017 WL 3220445
Only the Westlaw citation is currently available.

United States District Court,
E.D. Arkansas, Western Division.

Frederick W. HOPKINS, M.D., M.P.H., Plaintiff
v.
Larry JEGLEY, Prosecuting Attorney for Pulaski County, Steven L. Cathey, M.D., Chair of the Arkansas State Medical Board; Robert Breving, Jr., M.D.; Bob E. Cogburn, M.D.; William F. Dudding, M.D.; Omar T. Atiq, M.D.; Veryl D. Hodges, D.O.; Marie Holder; Larry D. Lovell; William L. Rutledge, M.D.; John H. Scribner, M.D.; Sylvia D. Simon, M.D.; David L. Staggs, M.D.; John B. Weiss, M.D., officers and members of the Arkansas State Medical Board, and their successors in office, in their official capacity, Defendants

Case No. 4:17-cv-00404-KGB
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Filed 07/28/2017

Synopsis

Background: Physician brought § 1983 action against prosecuting attorney for county and officers and members of Arkansas State Medical Board, seeking declaratory and injunctive relief challenging constitutionality of state statutes regulating abortions. Physician filed motion for preliminary injunction.

Holdings: The District Court, Kristine G. Baker, J., held that:

[1] physician had standing to maintain action challenging constitutionality of Arkansas statutes regulating abortions, although statutes had not yet been enforced against him;

[2] physician could assert third-party rights on behalf of hypothetical future patients under § 1983;

[3] Eleventh Amendment did not preclude jurisdiction over state officials;

[4] physician was likely to succeed on merits of claim that state statute placed an undue burden on patients' rights to liberty and privacy;

[5] enforcement of state statute would inflict irreparable harm on physician and patients;

[6] threatened harm to physician and patients clearly outweighed any damage or harm proposed injunction may cause state officials; and

[7] public interest weighed in favor of preliminary injunction.

Motion granted.

Attorneys and Law Firms

Bettina E. Brownstein, Betinna E. Brownstein Law Firm, Little Rock, AR, Hillary A. Schneller, Center for Reproductive Rights, Pro Hac Vice, Elizabeth K. Watson, Ruth E. Harlow, Pro Hac Vice, Susan Talcott Camp, American Civil Liberties Union, New York, NY, for Plaintiff.

Jennifer L. Merritt, Nicholas Jacob Bronni, Michael Cantrell, Arkansas Attorney General's Office, Monty Vaughan Baugh, Monty V. Baugh, PLC, Little Rock, AR, for Defendants.

PRELIMINARY INJUNCTION ORDER

Kristine G. Baker, United States District Judge

*1 Plaintiff, Frederick W. Hopkins, M.D., M.P.H., files this suit pursuant to 42 U.S.C. § 1983 against defendants Larry Jegley, Prosecuting Attorney for Pulaski County; Steven L. Cathey, M.D., Chair of the Arkansas State Medical Board; and Robert Breving, Jr., M.D.; Bob Cogburn, J.D.; William F. Dudding, M.D.; Omar T. Atiq, M.D.; Veryl D. Hodges, D.O.; Marie Holder, Larry D. Lovell; William L. Rutledge, M.D.; John H. Scribner, M.D.; Sylvia D. Simon, M.D.; David L. Staggs, M.D.; and John B. Weiss, M.D., as officers and members of the Arkansas State Medical Board in their official capacities.

Dr. Hopkins mounts a constitutional challenge to four acts of the 91st Arkansas General Assembly of 2017, Act 45 (H.B. 1032) ("D & E Mandate"), Act 733 (H.B. 1434) ("Medical Records Mandate"), Act 1018 (H.B. 2024) ("Local Disclosure Mandate"), and Act 603 (H.B. 1566) ("Tissue Disposal Mandate"), to be codified at Arkansas Code Annotated §§ 20–16–1801 to 1807, 20–16–1801 to 1810, 12–18–108(a)(1), and 20–17–801 to 802, respectively. [1] By its terms, H.B. 1434 takes effect January 1, 2018. The remaining three laws, H.B. 1032, H.B. 2024, and H.B. 1566, are set to take effect on or about July 30, 2017.

Before the Court is Dr. Hopkins's motion for preliminary injunction or in the alternative temporary restraining order (Dkt. No. 2). Dr. Hopkins seeks preliminary injunctive relief based on the following claims in his complaint: Count 1 based on the D & E Mandate, Counts III and IV based on the Medical Records Mandate, Counts VI and VIII based on the Local Disclosure Mandate, and Counts X and XI based on the Tissue Disposal Mandate. Dr. Hopkins claims that "[t]hese statutes threaten [him] with criminal penalties and deny and burden [his] patients' constitutionally protected rights to decide to end a pre-viability pregnancy, to make independent decisions related to their pregnancy care, and to protect their private medical information." (Dkt. No. 1, at 3, ¶ 9). He seeks declaratory and injunctive relief "[t]o protect his patients from these constitutional violations, to enforce his own right to clear legal standards, and to avoid irreparable harm...." (Dkt. No. 1, at 3, ¶ 9). Defendants responded in opposition to the motion (Dkt. No. 23). Dr. Hopkins filed a reply (Dkt. No. 32). Defendants also submitted two notices of supplemental authority (Dkt. Nos. 31, 34).

The Court conducted a hearing on the motion on July 13, 2017. The parties agreed among themselves not to present additional evidence at the hearing but instead to present only argument, and the Court agreed to hear only argument. For the following reasons, the Court grants Dr. Hopkins's motion for preliminary injunction.

I. Findings of Fact

*2 1. Dr. Hopkins is a board-certified obstetrician-gynecologist with 25 years of experience in women's health. He is licensed to practice medicine in Arkansas, as well as other states including California and New Mexico. For over five years, Dr. Hopkins has been both Co-Director of the Family Planning Training Program at Santa Clara Valley Medical Center in Santa Clara, California, and Associate Clinical Professor in obstetrics and gynecology at Stanford University School of Medicine in Palo Alto, California (Dkt. No. 5, ¶ 1).

2. Earlier in 2017, Dr. Hopkins began providing care at Little Rock Family Planning Services in Little Rock, Arkansas (Dkt. No. 5, ¶ 1).

3. At Little Rock Family Planning Services, Dr. Hopkins provides care that includes medication abortion in the early part of the first trimester and surgical abortion through 21 weeks and six days as measured from the woman's last menstrual period ("LMP"), which is referred to as "21.6 weeks LMP" (Dkt. No. 5, ¶ 2; Dkt. No. 6, ¶ 2).

4. Dr. Hopkins provides abortion and miscarriage services for patients from young teenagers to women in their later reproductive years (Dkt. No. 5, ¶ 2).

5. Dr. Hopkins has performed work in Kenya, Tanzania, and Zimbabwe. As a result of that work, he has seen firsthand the results of denying women access to safe abortion care (Dkt. No. 5, ¶ 3).

6. There are only two entities providing abortion care in Arkansas: Little Rock Family Planning Services, which provides abortions through 21.6 weeks LMP, and Planned Parenthood Great Plains, which provides only medication abortion through 10 weeks LMP in Little Rock and Fayetteville, Arkansas (Dkt. No. 5, ¶ 6; Dkt. No. 6, ¶ 2).

7. If hospitals in Arkansas are providing any abortion care, it is in only rare circumstances (Dkt. No. 5, ¶ 6).

8. Under current Arkansas law, a woman must first receive state-mandated counseling, in person at the clinic before having an abortion. *See* Ark. Code Ann. § 20–16–1703(b)(1), (2). A woman must then wait 48 hours after that state-mandated counseling before she returns to the clinic for her procedure (Dkt. No. 5, ¶ 7; Dkt. No. 6, ¶ 7).

9. Given the requirements of Arkansas law regarding mandated state counseling, for patients receiving abortion care up to 18.0 weeks LMP, the law requires at least two trips to the clinic (Dkt. No. 6, ¶ 7).

10. According to Dr. Hopkins, the state-mandated counseling and 48–hour waiting period can result in a delay longer than 48 hours for many patients (Dkt. No. 5, ¶ 7).

11. Women must consider whether they have someone to accompany them to the clinic. The support person's availability may impact when a woman is able to return, after the mandatory delay, to receive medical care (Dkt. No. 6, ¶ 7).

12. Little Rock Family Planning Services provides care to women from throughout Arkansas and from other states (Dkt. No. 5, at 37; Dkt. No. 6, ¶ 5).

13. Many patients of Little Rock Family Planning Services are low-income. Approximately 30 to 40% of patients obtain financial assistance to pay for their abortion care (Dkt. No. 6, ¶ 5).

14. Many patients of Little Rock Family Planning Services struggle in their lives and in their efforts to access the medical care they need (Dkt. No. 6, ¶ 5).

15. The time and effort it takes to make the necessary plans to access medical care cause anxiety and stress and cause financial pressure for women seeking care at Little Rock Family Planning Services. Women must arrange for time off work on multiple days, which can be very difficult given that many are in low-wage jobs and feel that they cannot explain to an employer the reason they need to take time off. For women who already have children, these women must arrange and often pay for childcare. These women also must arrange and pay for transportation. In some cases, these women also have to arrange and pay for a place to stay for multiple nights (Dkt. No. 6, ¶ 8).

*3 16. Patients of Little Rock Family Planning Services seek abortions for a variety of personal, medical, financial, and family reasons, including that the woman has one child but believes she cannot parent another; that the woman believes she is too young to be ready to carry a pregnancy or to become a parent; that the woman is pursuing educational or work opportunities; that the woman has a health condition that makes carrying a pregnancy dangerous; that the woman has received a diagnosis of fetal abnormality; that the woman is in an abusive relationship; and that the woman is pregnant as a result of rape or sexual assault (Dkt. No. 6, ¶ 6).

17. Many patients of Little Rock Family Planning Services are desperate not to disclose the reasons for travel and appointments to seek abortion care (Dkt. No. 6, ¶ 8).

18. Approximately 30% of all women have an abortion at some point in their lives (Dkt. No. 4, ¶ 7).

19. Abortion in the first and second trimester, utilizing current methods, is safer than carrying a pregnancy to term, as to both morbidity and mortality (Dkt. No. 4, ¶ 8; Dkt. No. 32–1, ¶ 5).

20. The first trimester of pregnancy goes to approximately 14 weeks LMP (Dkt. No. 5, ¶ 8).

21. Nationwide, approximately 90% of abortions occur during the first trimester of pregnancy (Dkt. No. 5, ¶ 8).

22. In Arkansas, approximately 83% of abortions occur during the first trimester of pregnancy (*Id.*).

23. During the first trimester, there are two methods of abortion (Dkt. No. 4, ¶ 11–12; Dkt. No. 5, ¶ 9).

24. As for the first method used during the first trimester, a clinician may use medications to induce an early miscarriage. This method is called early medication abortion. It is generally available only through part of the first trimester of pregnancy, and it is not available in the last weeks of the first trimester of pregnancy. In the most common method of early medication abortion, a woman takes two drugs: first mifepristone and then, the next day, misoprostol. Within 24 to 48 hours of taking the second drug, the woman likely will pass the products of conception, not in a medical facility but in a location that is most comfortable for her, usually her home (Dkt. No. 4, ¶ 11–12; Dkt. No. 5, ¶ 9).

25. Dr. Hopkins does not know the exact timing of the most common method of early medication abortion because he is not with his patient when she passes the products of conception (Dkt. No. 5, ¶ 9).

26. As for the second method used during the second trimester, a clinician may use suction to empty the uterus, which is available through the entire first trimester. This method is called suction or aspiration abortion. The clinician first gently opens the cervix and then

inserts a suction cannula into the uterus, and suctions out the embryo (until approximately 10 weeks) or fetus (thereafter)—as well as the placenta, amniotic fluid, and sac, and the other contents of the uterus (Dkt. No. 4, ¶ 13; Dkt. No. 5, ¶ 10).

27. In the second trimester of pregnancy, suction alone generally is not sufficient to complete an abortion, nor is it something physicians can rely on to cause fetal demise to avoid liability under the D & E Mandate in the second trimester (Dkt. No. 32–1, ¶ 5).

28. In the second trimester of pregnancy, beginning at approximately 14.0 weeks LMP, there are two principal methods of abortion (Dkt. No. 4, ¶ 14; Dkt. No. 5, ¶ 11).

29. As for the first method used beginning at approximately 14.0 weeks LMP, in induction abortion, the clinician uses medications to induce labor. This procedure can happen only in a hospital or hospital-like facility, not in a second-trimester outpatient clinic. This procedure can take over 24 hours, and for some patients, this procedure may span multiple days. This procedure entails labor, which can involve pain requiring significant medication or anesthesia, and which may be psychologically challenging for some women. This procedure accounts for a tiny fraction of second-trimester abortions in the nation (Dkt. No. 4, ¶ 14; Dkt. No. 5, ¶ 12).

*4 30. Because induction involves an in-patient stay, requiring up to three days of hospitalization, as opposed to an out-patient procedure, there is an enormous cost difference between induction and the out-patient standard dilation and evacuation ("standard D & E") procedure [2] (Dkt. No. 4, ¶ 14).

31. In some women, an induction abortion fails, and the woman needs intervention in the form of D & E for her safety. This is infrequent, but this does occur (Dkt. No. 4, ¶ 15; Dkt. No. 5, ¶ 12).

32. In approximately 5% to 10% of induction abortions, the woman must undergo an additional surgical procedure to remove a retained placenta. Induction abortion also can cause uterine rupture, which is rare but can be life threatening and can be of particular concern for women who have had multiple previous cesarean deliveries (Dkt. No. 4, ¶ 15; Dkt. No. 25–4, ¶ 8).

33. Of women who have abortions performed during the second trimester of pregnancy, 95% of those women in this country choose standard D & E (Dkt. No. 4, ¶ 16).

34. In 2015, the latest year for which statistics are available, there were no induction abortions reported in Arkansas (Dkt. No. 5, ¶ 12).

35. As for the second method used beginning at approximately 14 weeks LMP, because suction instruments alone are generally no longer sufficient to empty the uterus, doctors can use a method with instrumentation called standard D & E. This involves two steps: dilating the cervix, and then evacuating the uterus with instruments such as forceps. There are several ways to dilate the cervix (Dkt. No. 4, ¶ 17; Dkt. No. 5, ¶ 13).

36. Typically, during the early weeks of the second trimester of pregnancy, a doctor performing standard D & E uses a combination of medications that open the cervix and manual dilators; then, the same day, the doctor uses forceps to remove the fetus and other contents of the uterus. Because the fetus is larger than the opening of the cervix, the fetal tissue generally comes apart as the physician removes it through the cervix. The reason that the cervical opening is smaller than the fetal parts is that, in general, the doctor dilates only enough to allow the safe passage of instruments and fetal tissue through the cervix (Dkt. No. 4, ¶ 17–18; Dkt. No. 5, ¶ 14).

37. In Arkansas and elsewhere, standard D & E typically is a one-day procedure from 14.0 to 17.6 weeks LMP (Dkt. No. 5, ¶ 15; Dkt. No. 6, ¶ 17).

38. Of 638 D & Es reported in Arkansas in 2015, 407 or 64% took place during these earliest weeks of the second trimester (Dkt. No. 6, ¶ 17).

39. Dr. Hopkins is aware of no physicians, other than those with whom he practices at Little Rock Family Planning Services, who provide second trimester abortion care in the state of Arkansas (Dkt. No. 32–2, ¶ 2).

40. Later in the second trimester, larger instruments require wider cervical dilation. Although some physicians continue to provide standard D & E as a one-day procedure, starting at 18.0 to 20.0 weeks LMP, it is typical for doctors to add overnight osmotic dilation to the standard D & E protocol. Osmotic dilators are thin

sticks of material that swell when they absorb moisture; when placed in a woman's cervix, they absorb moisture from the woman's body, expand slowly, and slowly dilate the cervix. Once dilation is sufficient, typically the next day, the doctor proceeds as in earlier standard D & Es, removing the fetus, generally in pieces because it is larger than the cervical opening (Dkt. No. 4, ¶ 17; Dkt. No. 5, ¶ 16).

*5 41. For patients of Little Rock Family Planning Services who have overnight osmotic dilation with the standard D & E protocol, those patients are required to spend that overnight within 30 minutes of the Clinic so that the doctor is available in the rare instance in which a patient has any problem (Dkt. No. 6, ¶ 18).

42. Through the second trimester, standard D & E is a safe way to provide abortion in an outpatient setting, such as a family planning clinic (Dkt. No. 5, ¶ 17).

43. Standard D & E accounts for almost all second-trimester abortions in the United States (Dkt. No. 4, ¶ 16; Dkt. No. 5, ¶ 17).

44. Standard D & E accounts for 100% of second trimester abortions reported in Arkansas in 2015 (Dkt. No. 5, ¶ 17).

45. Each year, Little Rock Family Planning Services provides approximately 3,000 abortions, of which approximately 600 or 20% occur during the second trimester (Dkt. No. 6, ¶ 16).

46. Standard D & E procedure has a long-established safety record in this county, with major complications occurring in less than 1% of standard D & E procedures (Dkt. No. 4, ¶ 19).

47. Richard A. Wyatt, M.D., an expert for defendants, states that "[b]y the 14th week of pregnancy a living baby has a beating heart and moving limbs, and breathing motions have begun." (Dkt. No. 25–4, ¶ 4). At this time, and on the record before it, this Court does not equate Dr. Wyatt's use of "living baby" with viability, as the term viability has been used by courts in the abortion context. *See Edwards v. Beck*, 8 F.Supp.3d 1091 (E.D. Ark. 2014), *aff'd* 786 F.3d 1113 (8th Cir. 2015) (examining the term viability in both medical and legal contexts).

48. Given the requirements of Arkansas law regarding mandated state counseling, for patients receiving abortion care at 18.0 to 21.6 weeks LMP, the law requires at least three trips to the clinic (Dkt. No. 6, ¶ 7).

49. Starting at 18.0 to 22.0 weeks, some physicians, including Dr. Hopkins, undertake an additional procedure to try to cause fetal demise before the evacuation phase of a D & E for most patients, meaning those for whom it is not contraindicated (Dkt. No. 5, ¶ 18).

50. Of the physicians who undertake an additional procedure after 18.0 to 22.0 weeks LMP, the vast majority of physicians inject the drug digoxin into the fetus if possible or, if not, then into the amniotic fluid. Injecting digoxin into the amniotic fluid is technically easier, but it is less effective (Dkt. No. 4, ¶ 21; Dkt. No. 5, ¶ 18).

51. The injections may be through the woman's abdomen or vaginal wall. These injections generally use an 18– to 22–gauge spinal needle, passed under ultrasound guidance, through the patient's abdomen, vaginal wall, or vagina and cervix, and then either into the amniotic fluid or the fetus (Dkt. No. 4, ¶ 21, 25; Dkt. No. 5, ¶ 18).

52. There are some women for whom an injection of digoxin may be difficult or impossible. For example, woman may be very obese; may have anatomical variations of the uterine and vaginal anatomy, such as fibroids or a long cervix; and may have fetal positioning that creates issues. Physicians cited by all parties agree upon this (Dkt. No. 4, ¶ 27; Dkt No. 5, ¶ 25a; Dkt. No. 25–4, ¶ 6; Dkt. No. 32–3, Biggio Cross, at 139; Dkt. No. 25–4, ¶ 6).

53. These injections also can be dangerous for women with cardiac conditions such as arrhythmias (Dkt. No. 4, ¶ 27).

*6 54. Even for women who tolerate injections, digoxin will not cause fetal demise in 5% to 10% of all cases in which it is used; physicians cited by all parties agree upon this (Dkt. No. 4, ¶ 28; Dkt. No. 5, ¶ 25b; Dkt. No. 32–3, Biggio Cross, at 142).

55. Doctors are not able to know in advance for which women digoxin injection will fail (Dkt. No. 5, ¶ 25c).

56. The failure rate is higher for intramniotic injections of digoxin. Intramniotic injection would require a skill level

similar to that required for amniocentesis. Intramniotic injections are associated with higher complication rates than intrafetal injection (Dkt. No. 4, ¶ 25; Dkt. No. 32–1, ¶ 7).

57. Intrafetal injections of digoxin are more difficult to perform and may be impossible to perform due to fetal position, uterine anatomy and other factors, especially the size of the fetus. The smaller the fetus, the more difficult intrafetal injection will be. Intrafetal digoxin injections require additional skill (Dkt. No. 4, ¶ 28; Dkt. No. 32–1, ¶ 7).

58. Digoxin works very slowly. Doctors allow 24 hours after the injection for it to work. Even then, it does not always cause fetal demise (Dkt. No. 5, ¶ 18).

59. The transabdominal injection can be painful and emotionally difficult for the patient. The injection poses risks, including infection, which can threaten the patient's health and future fertility, and accidental absorption of the drug into the patient's circulation, which can result in toxicity and changes to the patient's EKG (Dkt. No. 4, ¶ 25).

60. Like all medical procedures, the digoxin injection creates risks for the patient. Doctors who use digoxin believe that practical concerns justify using it. The main benefit of using digoxin in procedures after 18.0 to 22.0 weeks LMP is to establish compliance with the federal "partial-birth abortion ban" or similar state laws (Dkt. No. 4, ¶ 23; Dkt. No. 5, ¶ 19).

61. The federal "partial-birth abortion ban" has an intent requirement (Dkt. No. 4, ¶ 23).

62. The American Congress of Obstetricians and Gynecologists ("ACOG") concluded: "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion." This statement is consistent with the medical literature (Dkt. No. 4, ¶ 22; Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin Number 135: Second Trimester Abortion, 121(6) Obstetrics & Gynecology 1394, 1396, 1406 (2013)).

63. There is no record evidence of any physician attempting digoxin injections earlier than 18 weeks LMP. Physicians relied upon by both sides agree upon this (Dkt. No. 4, ¶ 26; Dkt. No. 32–3, Biggio Cross, at 143).

64. There are virtually no reported studies, and no studies of record, on using digoxin in the first weeks of the second trimester, when most second trimester abortions are performed. Without studies, doctors do not know the risks, complication rates, or effectiveness of such a procedure. Without this information, doctors cannot counsel patients on the effectiveness or safety of such a procedure (Dkt. No. 4, ¶ 26; Dkt. No. 32–1, ¶ 6, 9–10; Dkt. No. 32–3, Biggio Cross, at 143–44).

65. There are no reported studies of record on using a second injection of digoxin, or multiple, sequential injections of digoxin, after the first dose fails to bring about fetal demise. Physicians relied upon by both sides agree on this (Dkt. No. 4, ¶ 29; Dkt. No. 23–15, ¶ 6; Dkt. No. 32–3, Biggio Cross, at 142).

*7 66. Using a second injection of digoxin would, at a minimum, delay the abortion procedure, require the patient to make another trip to the clinic, and increase the risk of uterine infection, extramural delivery, or digoxin toxicity (Dkt. No. 4, ¶ 29).

67. In Arkansas, the standard D & E protocol changes in two ways starting at 18.0 weeks LMP for almost all patients (Dkt. No. 5, ¶ 20).

68. First, in Arkansas, a woman at 18.0 weeks LMP receives overnight dilation. This means that the abortion procedure takes two days, rather than one (Dkt. No. 5, ¶ 20).

69. Second, in Arkansas, at the time a woman at 18.0 weeks LMP has placed in her cervix the osmotic dilators, which is the day before the intended evacuation, the woman also receives an injection of digoxin through the vaginal wall. That injection of digoxin is into the fetus or, if not, into the amniotic fluid. With either method of injection, the digoxin may not work effectively (Dkt. No. 5, ¶ 20).

70. The next day, in women 18.0 weeks or later LMP, if the digoxin has not caused fetal demise, Dr. Hopkins currently will take steps with his forceps, such as compressing fetal parts, to ensure fetal demise and to establish compliance with existing laws. These women

would already be dilated and, therefore, at risk without care (Dkt. No. 5, ¶¶ 21, 25b).

71. Another substance, potassium chloride (KCl), will cause fetal demise if injected directly into the fetal heart, which is extremely small (Dkt. No. 4, ¶ 31; Dkt. No. 5, ¶ 22).

72. Injecting potassium chloride has limitations based on gestational age and anatomy (Dkt. No. 25–4, ¶ 6).

73. The procedure of injecting potassium chloride is very rare, as it carries much more severe risks for the woman, including death if the doctor places the solution in the wrong place, and it requires extensive training generally available only to sub-specialists in high-risk obstetrics, known as maternal-fetal medicine (Dkt. No. 4, ¶ 31; Dkt. No. 5, ¶ 22; Dkt. No. 23–15, ¶ 11; Dkt. No. 32–2, ¶ 3; Dkt. No. 32–3).[3]

74. Injecting potassium chloride is usually done in a hospital, not a clinical, setting. The procedure requires an advanced ultrasound machine that is typically available only in a hospital setting and too expensive for most clinics to afford (Dkt. No. 4, ¶ 31; Dkt. No. 32–2, ¶ 3; Dkt. No. 32–3, Biggio Direct, at 111, Biggio Cross, at 140–41).

75. There are some women for whom injecting potassium chloride is not medically appropriate (Dkt. No. 4, ¶ 31).

76. Neither Dr. Hopkins nor to his knowledge any of the physicians with whom he practices at Little rock Family Planning Services have the specialized training in the sub-specialty of high-risk obstetrics necessary to safely inject potassium chloride (Dkt. No. 5, ¶ 22).

*8 77. Umbilical cord transection involves the physician rupturing the membranes, inserting a suction tube or other instrument such as forceps into the uterus, and grasping the cord, if possible, to divide it with gentle traction, which will cause demise over the course of up to 5 to 10 minutes (Dkt. No. 4, ¶ 32; Dkt. No. 23–15, ¶ 8).

78. The success and ease of this procedure depends on placement of the umbilical cord. If the umbilical cord is blocked by the fetus, it would be very difficult and very risky to attempt to reach it (Dkt. No. 4, ¶ 33).

79. Umbilical cord transection is not widely practiced or researched (Dkt. No. 4, ¶ 32).

80. There has been only one scientific study on the use of cord transection to cause fetal demise; physicians relied upon by both sides agree on this (Dkt. No. 32–1, ¶ 11; Dkt. No. 32–3, Biggio Cross, at 146).

81. The one scientific study on the use of cord transection has limitations and does not support any conclusion about the safety of the procedure (Dkt. No. 32–1, ¶¶ 12–13).

82. Attempting umbilical cord transection before 16.0 weeks LMP is completely unstudied, and like injections, these procedures are more difficult to perform the earlier in pregnancy a woman seeks care. Successfully identifying and transecting the cord at early gestations would take additional time and likely multiple passes with forceps (Dkt. No. 32–1, ¶¶ 14–15).

83. There are some women for whom umbilical cord transection is not medically appropriate; physicians relied upon by both parties agree on this (Dkt. No. 4, ¶ 32; Dkt. No. 23–15, ¶ 12).

84. Mark D. Nichols, M.D., an expert upon whom Dr. Hopkins relies, does not perform umbilical cord transection (Dkt. No. 4, ¶¶ 32–35; Dkt. No. 32–1, ¶¶ 11–15).

85. No physician to which either party cites would require cord transection in their respective practices (Dkt. No. 4, ¶ 34; Dkt. No. 5, ¶ 25d; Dkt. No. 32–3, Biggio Cross, at 144).

86. Joseph R. Biggio, Jr., M.D., an expert upon whom defendants rely, admits that he would not require umbilical cord transection before every abortion because there is no medical benefit to doing so (Dkt. No. 32–2, at 144).

87. The longer a D & E takes and the more instrument passes into the woman's uterus occur, the higher the risks of uterine perforation and other complications; physicians relied upon by both sides agree on this (Dkt. No. 4, ¶¶ 32–34; Dkt. No. 5, ¶ 25d; Dkt. No. 32–1, ¶¶ 13, 15; Dkt. No. 23–15, ¶ 8; Dkt. No. 32–3, Biggio Cross, at 144–45; Dkt. No. 25–4, ¶ 6).

88. Delay can push a woman past the point in pregnancy at which she can receive a medication abortion, requiring a woman who prefers that method to have a procedure with instrumentation that she would otherwise not have. Delay can push a woman from a first-trimester to a second-trimester procedure, or from a one-day to a two-day procedure in the second trimester. Delay can also push a woman past the point at which she can obtain an abortion at Little Rock Family Planning Services and in Arkansas (Dkt. No. 6, ¶ 13).

89. The risks associated with legal abortion utilizing current methods increase as pregnancy progresses, particularly if that delay pushes a woman from the first trimester to the second trimester. Studies demonstrate increased risks of complications, such as bleeding and uterine perforation, associated with abortions performed later in pregnancy (Dkt. No. 4, ¶ 10; *see also* Dkt. No. 25–4, ¶ 7).

*9 90. Delay also means that a woman may pay more for the abortion procedure itself because the procedure becomes more complex as pregnancy advances (Dkt. No. 6, ¶ 14).

91. Doctors at Little Rock Family Planning Services request medical records for only a "tiny fraction" of patients or approximately 25 patients per year (Dkt. No. 6, ¶ 24).

92. The patients for whom doctors at Little Rock Family Planning Services request medical records include patients who have received a diagnosis of fetal anomaly, decided to end the pregnancy, and received a referral to Little Rock Family Planning Services and patients for whom the doctor believes the records could be useful because of a woman's medical condition (Dkt. No. 6, ¶ 24).

93. For Little Rock Family Planning Services to obtain a patient's medical records, the patient must first sign a form authorizing Little Rock Family Planning Services to obtain the medical records. That authorization is then sent along with a request to the health care provider. Little Rock Family Planning Services staff then follow-up with a phone call to the health care provider, if necessary (Dkt. No. 6, ¶ 25).

94. Because Little Rock Family Planning Services typically requests records related to some aspect of the care the patient will receive, and therefore involve a specific request, not a request for the patient's full medical history, there is no fee charged for the records (Dkt. No. 6, ¶ 25).

95. Even with these specific requests for records, it takes time to obtain a patient's medical records from another health care provider and may take a few hours or up to several weeks (Dkt. No. 6, ¶ 26).

96. When making a request for a patient's complete medical record, a fee usually is charged for obtaining the records (Dkt. No. 6, ¶ 33).

97. Little Rock Family Planning Services is a well-known abortion provider. Any request for medical records made by Little Rock Family Planning Services, in and of itself, discloses that the patient likely is seeking an abortion. As a result, Little Rock Family Planning Services does not request records without a woman's prior written consent, and some women specifically request that Little Rock Family Planning Services not seek records from another health care provider because the women do not want that provider to know of the pregnancy and abortion decision (Dkt. No. 6, ¶ 27).

98. Some women have informed Little Rock Family Planning Services that the women fear hostility or harassment from the other health care providers for deciding to seek an abortion (Dkt. No. 6, ¶ 28).

99. A few years ago, Little Rock Family Planning Services requested a woman's medical records from another health care provider and that provider's wife then reached out to the woman in an effort to dissuade her from having an abortion (Dkt. No. 6, ¶ 28).

100. Little Rock Family Planning Services provides medical care to approximately 3,000 women each year, the majority of whom have had one or more prior pregnancies, during which the women received medical care from one or more providers or received care for a current pregnancy (Dkt. No. 6, ¶ 32).

101. Under Arkansas law, a woman under the age of 18 must obtain the consent of one parent prior to obtaining an abortion or, alternatively, can seek a judicial bypass (Dkt. No. 6, ¶ 36). *See* Ark. Code Ann. § 20–16–804.

*10 102. In 2016, Little Rock Family Planning Services provided abortions to five minors under the age of 14, all five of whom had parental consent, and 69 minors under the age of 17, all of whom except one had parental consent with the one exception having received a judicial bypass (Dkt. No. 6, ¶ 36).

103. The numbers from 2016 are typical for Little Rock Family Planning Services in that the majority of women under the age of 17 have obtained a parent's consent to seek medical care at Little Rock Family Planning Services (Dkt. No. 6, ¶ 36).

104. A few minor patients of Little Rock Family Planning Services are married, and those patients' husbands may or may not be involved in the patients' decisions to have an abortion (Dkt. No. 6, ¶ 37).

105. Under the Child Maltreatment Act, Little Rock Family Planning Services reports suspected abuse to the Arkansas State Police's Child Abuse Hotline (Dkt. No. 6, ¶ 38). *See* Ark. Code Ann. § 12–18–402 (providing that mandated reporters "shall immediately notify the Child Abuse Hotline" if they have reasonable cause to suspect child abuse, and listing reproductive healthcare facility employees and volunteers as mandatory reporters).

106. Under Arkansas law, for women who are 13 years old or younger, Little Rock Family Planning Services must preserve tissue and have local law enforcement in the jurisdiction in which the minor resides pick it up. Ark. Code Ann. § 12–18–108(a). Little Rock Family Planning Services sends a form to local law enforcement with information identifying the patient to alert local law enforcement to come pick up the tissue (Dkt. No. 6, ¶ 40); Ark. Code Ann. § 12–18–108(b)(5).

107. Compliance with this law requires, on occasion, Little Rock Family Planning Services to speak by telephone with local law enforcement and local law enforcement's obligation to comply with the law (Dkt. No. 6, ¶ 41).

108. Local law enforcement do not reliably comply with existing law by picking up the preserved tissue for patients who are 13 or younger ((Dkt. No. 6, ¶ 41).

109. Local law enforcement can be very small, with as few as two officers, and operate in small communities (Dkt. No. 6, ¶ 45).

110. On occasion, when a Little Rock Family Planning Services representative has spoken to local law enforcement about the existing law, personnel lecture the Little Rock Family Planning Services and "preach[ ] anti-abortion rhetoric, including telling [the representative] that the Clinic is taking a life." (Dkt. No. 6, ¶ 43).

111. Little Rock Family Planning Services, as a part of its routine counseling, discusses with the woman the age of her sexual partner (Dkt. No. 6, ¶ 38).

112. In general, when a crime has already been reported, law enforcement are involved before the minor visits Little Rock Family Planning Services, and law enforcement call Little Rock Family Planning Services before the minor patient arrives. When an investigation is involved, Little Rock Family Planning Services preserves tissue for law enforcement (Dkt. No. 6, ¶ 39).

113. For patients who are 13 or younger and reside out of state, Little Rock Family Planning Services makes the same efforts to contact the local police department where the minor resides (Dkt. No. 6, ¶ 42).

114. Unlike the State Child Abuse Hotline, which is associated with a unit whose staff have specialized training in child maltreatment and handling these complicated issues, local law enforcement does not have the same kind of specialized unit or training (Dkt. No. 6, ¶ 43).

*11 115. Under an Arkansas law enacted in 2015, Little Rock Family Planning Services obtains each patient's consent in writing to having the embryonic or fetal tissue from her abortion disposed of within 48 hours (Dkt. No. 6, ¶ 50); *See* Ark. Code Ann. § 20–17–801(b).

116. Currently, Little Rock Family Planning Services contracts with a vendor that transports tissue generated at the Clinic out of Arkansas to be disposed of by incineration (Dkt. No. 6, ¶ 49).

117. Currently, a few patients of Little Rock Family Planning Services each year wish to have their tissue cremated and make those arrangements themselves (Dkt. No. 6, ¶ 49).

118. Currently, Little Rock Family Planning Services sends the pregnancy tissue of a few patients to pathology.

This may be done when a physician suspects a molar pregnancy or an abnormal growth of fetal tissue that can become a tumor or when the patient received a diagnosed fetal anomaly (Dkt. No. 6, ¶ 53).

119. In a medication abortion, the patient passes the pregnancy tissue at home over a period of hours or days, but she collects and disposes of it as she would during menstruation (Dkt. No. 6, ¶ 52).

120. The record includes affidavits from individual women who describe mental distress resulting from their individual choices to have abortions and an affidavit from one abortion counselor who claims to have witnessed these reactions in other women with whom she has interacted in a post-abortion support group setting (Dkt. No. 25–12; Dkt. No. 25–14; Dkt. No. 25–15; Dkt. No. 25–16).

121. The American Psychiatric Association rejected the notion that abortion causes mental distress (Dkt. No. 32–1, ¶ 16).

122. Individual patients may experience a full range of emotional and psychological responses to having an abortion, but well-designed and rigorous research concludes that there is no evidence that abortion causes mental health problems (Dkt. No. 32–1, ¶¶ 16–18).

123. In Arkansas, 3,771 abortions were performed in 2015 (Dkt. No. 5, Ex. B). Of those, 581 were medication abortion and 3,190 were not. Of the 3,771 total abortions in 2015 in Arkansas, 528 were obtained by married women, and 3,234 were obtained by not married women (*Id.*). Nine individuals reported "unknown" when asked marital status (*Id.*). Of the 3,771 total abortions in 2015 in Arkansas, 141 were obtained by individuals below the age of 18 (*Id.*).

II. Threshold Matters

Defendants filed a motion to dismiss, which first became ripe on July 25, 2017 (Dkt. Nos. 21, 33). In that motion, defendants raise several threshold matters upon which this Court must rule before turning to the merits of this case. The Court must satisfy itself that the parties and these disputes are properly before the Court.

A. Article III Standing

[1] [2] Defendants first contend that Dr. Hopkins purportedly lacks standing to assert challenges to these Acts and that, therefore, the Court should dismiss this action. "Article III, § 2, of the Constitution restricts the federal 'judicial [p]ower' to the resolution of 'Cases' and 'Controversies.' " *Sprint Commc'ns Co., L.P. v. APCC Servs., Inc.*, 554 U.S. 269, 273, 128 S.Ct. 2531, 171 L.Ed.2d 424 (2008). Dr. Hopkins has the burden of establishing that he has standing. *Id.* To demonstrate "Article III" standing, a plaintiff must demonstrate:

> ***12** (1) [A]n injury in fact (*i.e.*, a "concrete and particularized" invasion of a "legally protected interest"); (2) causation (*i.e.*, a " 'fairly ... trace[able]' " connection between the alleged injury in fact and the alleged conduct of the defendant); and (3) redressability (*i.e.*, it is " 'likely' " and not "merely 'speculative' " that the plaintiff's injury will be remedied by the relief plaintiff seeks in bringing suit).

Id. at 273–74, 128 S.Ct. 2531 (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992)).

[3] In addition to the three "irreducible constitutional minimum" requirements of Article III standing, *Lujan*, 504 U.S. at 560, 112 S.Ct. 2130, courts weigh other "prudential" considerations in determining whether plaintiffs have standing. *United States v. Windsor*, —— U.S. ——, 133 S.Ct. 2675, 2685, 186 L.Ed.2d 808 (2013) (explaining the distinction between "the jurisdictional requirements of Article III and the prudential limits on its exercise").

Dr. Hopkins is identified in the complaint as "an experienced, highly credentialed and board-certified obstetrician-gynecologist, and an abortion provider at Little Rock Family Planning Services, the only provider of outpatient, second-trimester abortion care in Arkansas." (Dkt. No. 1, at 4, ¶ 13). Dr. Hopkins claims that the statutes he challenges "threaten [him] with criminal penalties and deny and burden [his] patients' constitutionally protected rights to decide to end a

pre-viability pregnancy, to make independent decisions related to their pregnancy care, and to protect their private medical information." (Dkt. No. 1, at 3, ¶ 9). He seeks declaratory and injunctive relief "[t]o protect his patients from these constitutional violations, to enforce his own right to clear legal standards, and to avoid irreparable harm...." (Dkt. No. 1, at 3, ¶ 9).

[4] In their filings, defendants make several arguments challenging standing in this case. As an initial matter, the United States Supreme Court held in *Doe v. Bolton*, 410 U.S. 179, 188, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973), that abortion doctors have first-party standing to challenge laws limiting abortion when, as in *Doe* and the current case, the doctors are subject to penalties for violation of the laws. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 903–04, 909, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992) (plurality opinion); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 911 (7th Cir. 2015); *Planned Parenthood of Greater Tex. Surg. Health Serv. v. Abbott II*, 748 F.3d 583, 598 (5th Cir. 2014) ("*Abbott II*"); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 794 (7th Cir. 2013); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976). Here, Dr. Hopkins faces criminal penalties under the D & E Mandate, the Medical Records Mandate, and the Tissue Disposal Mandate. Further, he faces licensing penalties under the Medical Records Mandate and the Local Disclosure Mandate, along with licensing penalties for alleged unprofessional conduct that includes criminal conviction under statutes such as the D & E Mandate, the Medical Records Mandate, and the Tissue Disposal Mandate. Defendants assert that Dr. Hopkins alleges that the Mandates violate his personal due process rights. Defendants maintain that Dr. Hopkins lacks standing to assert these claims because Dr. Hopkins cannot establish an "injury in fact," meaning "a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement." *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298, 99 S.Ct. 2301, 60 L.Ed.2d 895 (1979). Defendants concede that courts have held, in some circumstances, that a party need not expose himself to arrest or prosecution in order to challenge a criminal statute but that, even there, there must be "a credible threat of prosecution" before a plaintiff has standing to challenge the provision. *Babbitt*, 442 U.S. at 298, 99 S.Ct. 2301.

*13 This Court has rejected nearly identical arguments that the injury was "speculative and conjectural" because the challenged abortion law had not yet been enforced against the plaintiff physician, including by licensure action. *See Edwards v. Beck*, 8 F.Supp.3d 1091 (E.D. Ark. 2014), *aff'd* 786 F.3d 1113 (8th Cir. 2015). The law is well-settled that a plaintiff need not "first expose himself to actual... prosecution to be entitled to challenge a statute that he claims deters the exercise of his constitutional rights." *Steffel v. Thompson*, 415 U.S. 452, 459, 94 S.Ct. 1209, 39 L.Ed.2d 505 (1974). Courts have concurred even in the abortion context. *See, e.g., Danforth*, 428 U.S. at 62, 96 S.Ct. 2831; *Doe v. Bolton*, 410 U.S. at 188, 93 S.Ct. 739. Here, Dr. Hopkins's declaration demonstrates the impact and threat of these Mandates (Dkt. No. 5, ¶¶ 23–62).

The Court disagrees with defendants' argument that *Clapper v. Amnesty International*, 568 U.S. 398, 133 S.Ct. 1138, 185 L.Ed.2d 264 (2013), overruled this precedent. In *Clapper*, the Court determined plaintiffs, who were not directly targeted by the challenged law, relied upon a "highly attenuated chain of possibilities" and harm too speculative to satisfy the Article III injury requirement. *Id.* at 1144–48. The facts presented here are distinguishable, and *Clapper* does not control. The Court concludes that, based on controlling precedent and the claims alleged, Dr. Hopkins faces concrete, imminent injuries from enforcement of the challenged Mandates.

[5] Defendants also contend that Dr. Hopkins cannot assert the third-party rights of his hypothetical future patients. They maintain that Dr. Hopkins cannot demonstrate a "close relation" with abortion patients because he is challenging laws that were enacted to protect the health and safety of those patients. Defendants claim that this presents a conflict of interest between providers and patients, and third-party standing is forbidden if the interests of the litigant and the third-party rights-holder are even "potentially in conflict." *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 15, 124 S.Ct. 2301, 159 L.Ed.2d 98 (2004); *see also Kowalski v. Tesmer*, 543 U.S. 125, 135, 125 S.Ct. 564, 160 L.Ed.2d 519 (2004) (Thomas, J., concurring) (noting that third-party standing is disallowed when the litigants "may have very different interests from the individuals whose rights they are raising"); *Canfield Aviation, Inc. v. Nat'l Transp. Safety Bd.*, 854 F.2d 745, 748 (5th Cir. 1988) ("[C]ourts must be sure... that the litigant and the person whose rights he asserts have interests which are aligned.").

The United States Supreme Court in a plurality opinion in *Singleton v. Wulff*, 428 U.S. 106, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976), concluded that "it generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision." *Id.* at 118, 96 S.Ct. 2868. Other courts also have rejected this argument. *See Abbott II*, 748 F.3d at 589 n.9. *See also* ***Whole Woman's Health*** *v. Hellerstedt*, —— U.S. ——, 136 S.Ct. 2292, 195 L.Ed.2d 665 (2016) (adjudicating physicians' and clinics' 42 U.S.C. § 1983 action against abortion restrictions on behalf of themselves and their patients).

Defendants' claim regarding a purported conflict of interest could be made with respect to any abortion regulation that purports to advance a valid state interest, but courts have repeatedly allowed abortion providers to challenge such laws, determining that the providers' and women's interests are aligned and not adverse. *See, e.g., Bellotti v. Baird*, 443 U.S. 622, 627 n.5, 99 S.Ct. 3035, 61 L.Ed.2d 797 (1979) (holding that a physician plaintiff had standing to raise his minor patients' claims to determine whether a parental consent law should be upheld to protect the alleged vulnerability of minors); *Charles v. Carey*, 627 F.2d 772, 779 n.10 (7th Cir. 1980) (rejecting the state's claim of conflict of interest in a challenge to a counseling law designed to "protect women from abusive medical practices"). This has not defeated a providers' standing to challenge contraception restrictions. *See Carey v. Population Servs. Int'l*, 431 U.S. 678, 683–84, 690, 97 S.Ct. 2010, 52 L.Ed.2d 675 (1977) (granting third-party standing where the government defended a contraception restriction based on its interest in protecting health); *Eisenstadt v. Baird*, 405 U.S. 438, 445–46, 450, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972) (allowing a plaintiff to raise the rights of others seeking contraception where the government defended a restriction as "regulating the distribution of potentially harmful articles").

B. Considerations Under 42 U.S.C. § 1983

*14 [6] Defendants also contend that, even if Dr. Hopkins could avoid these alleged limits on third-party litigation, he still cannot assert third-party rights under 42 U.S.C. § 1983 because, defendants claim, § 1983 extends only to litigants who assert their *own* rights. Based on this, defendants contend the third-party claims may proceed only under the implied right of action established by the Supremacy Clause, and the claims cannot serve as a basis for attorneys' fees. *See Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 480 F.3d 734, 739–40 (5th Cir. 2007); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 333 (5th Cir. 2005).

There is no language in the statute that supports this argument. *See* 42 U.S.C. § 1983 (providing in pertinent part, "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress...."). This Court agrees with the reasoning of the Seventh Circuit Court of Appeals on this point and rejects defendants' argument regarding standing under § 1983. *See Van Hollen*, 738 F.3d at 794 95. The Supreme Court has repeatedly allowed abortion providers to raise the rights of their patients in cases brought under § 1983, and this Court will do the same. *See e.g.*, ***Whole Woman's Health***, 136 S.Ct. 2292; *Gonzales*, 550 U.S. 124, 127 S.Ct. 1610; *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 324–25, 126 S.Ct. 961, 163 L.Ed.2d 812 (2006) (noting that plaintiffs raised patients' claims in suit under 42 U.S.C. § 1983); *Bellotti v. Baird*, 428 U.S. 132, 136, 96 S.Ct. 2857, 49 L.Ed.2d 844 (1976) (same).

C. The Mandates' Private Rights of Action

[7] Defendants also contend that Dr. Hopkins lacks standing to challenge the Mandates' private rights of action "because any injury to [Dr.] Hopkins is not 'fairly traceable' to the defendants." (Dkt. No. 22, at 13). Defendants maintain that they possess no authority to enforce the complained-of provisions and, therefore, cannot be sued by Dr. Hopkins in a pre-enforcement challenge to the constitutionality of the particular statutory provisions, citing among other cases *Digital Recognition Network, Inc. v. Hutchinson*, 803 F.3d 952, 957–58 (8th Cir. 2015) (Dkt. No. 22, at 13). Defendants further argue that "none of the Acts empower any of the defendants to bring a private right of action for damages against an abortion provider, nor do the defendants have authority to otherwise enforce those provisions. Instead,

just like the act at issue in *Hutchinson*, the challenged provisions of the Acts here provide for enforcement through private actions for damages. Defendants are therefore not the proper parties to sue when claiming that such provisions are unconstitutional." (Dkt. No. 23, at 22–23).

Dr. Hopkins asserts that, "while it is true that two of the challenged laws—H.B. 1032's D & E Ban and H.B. 1434's Medical Records Mandate—create such private rights of action, each of the four laws provides for criminal prosecution and/or civil licensing enforcement by defendants .... There is thus no relevance to defendants' claim that they are 'immune from suit challenging the constitutionality of an act when it provided for enforcement *only* th[r]ough private actions for damages,' and that in such a suit, 'a federal court lacks jurisdiction to declare it unconstitutional or to provide any other relief.' " (Dkt. No. 32, at 12). *See, e.g., Casey*, 505 U.S. at 887–88, 112 S.Ct. 2791 (noting, as to spousal notification law the Court struck down, that "[a] physician who performs an abortion" for a married woman without spousal notice "will have his or her license revoked, and is liable to the husband for damages"). The private rights of action present in the D & E Mandate and the Local Disclosure Mandate do not deprive this Court of jurisdiction to address the constitutionality of the laws.

D. Sovereign Immunity Under The Eleventh Amendment

*15 **[8]** **[9]** **[10]** Dr. Hopkins seeks declaratory and injunctive relief. Defendants move to dismiss all of his claims under the Eleventh Amendment (Dkt. No. 22, at 18). "The Eleventh Amendment confirms the sovereign status of the States by shielding them from suits by individuals absent their consent." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 437, 124 S.Ct. 899, 157 L.Ed.2d 855 (2004) (citing *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44, 54, 116 S.Ct. 1114, 134 L.Ed.2d 252 (1996)). However, "[t]o ensure the enforcement of federal law ... the Eleventh Amendment permits suits for *prospective* injunctive relief against state officials acting in violation of federal law." *Id.* (emphasis added) (citing *Ex parte Young*, 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908)). "A state official is amenable to suit to enjoin the enforcement of an unconstitutional state statute only if the officer has 'some connection with the enforcement of the act.' " *Digital Recognition Network*, 803 F.3d at 960 (citing *Ex Parte Young*, 209 U.S. at 157, 28 S.Ct. 441).

[11] **[12]** To determine whether an action against state officials in their official capacities avoids an Eleventh Amendment bar to suit, "a court need only conduct a 'straightforward inquiry into whether [the] complaint alleges an ongoing violation of federal law and seeks relief properly characterized as prospective.' " *Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635, 645, 122 S.Ct. 1753, 152 L.Ed.2d 871 (2002) (quoting *Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261, 296, 117 S.Ct. 2028, 138 L.Ed.2d 438 (1997) (O'Connor, J., concurring). In this case, Dr. Hopkins seek declaratory relief declaring the Mandates as unconstitutional "[t]o protect his patients from these constitutional violations, to enforce his own right to clear legal standards, and to avoid irreparable harm...." (Dkt. No. 1, at 3, ¶ 9). In his complaint, Dr. Hopkins also seeks preliminary and permanent injunctive relief that would enjoin the enforcement of these Mandates. Dr. Hopkins's prayer for relief "clearly satisfies [the Court's] 'straightforward inquiry.' " *Verizon Maryland, Inc.*, 535 U.S. at 645, 122 S.Ct. 1753.

[13] Furthermore, defendants, who are sued in their official capacities, are amenable to suit in this action. Dr. Hopkins alleges, and defendants do not dispute, that:

> 14. Defendant Larry Jegley is the Prosecuting Attorney for Pulaski County, located at 224 South Spring Street, Little Rock, Arkansas. Prosecuting attorneys "shall commence and prosecute all criminal actions in which the state or any county in his district may be concerned." Ark. Code Ann. § 16–21–103. Defendant Jegley is responsible for criminal enforcement of H.B. 1032, H.B. 1566, and H.B. 1343. He and his agents and successors are sued in their official capacities.
>
> 15. Defendant Steven L. Cathey, M.D., is the Chair of the Arkansas State Medical Board. Defendants Robert Breving, Jr., M.D.; Bob Cogburn, J.D.; William F. Dudding, M.D.; Omar T. Atiq, M.D.; Veryl D. Hodges, D.O.; Marie Holder, Larry D. Lovell; William L. Rutledge, M.D.; John H. Scribner, M.D.; Sylvia D. Simon, M.D.; David L. Staggs, M.D.; and John B. Weiss, M.D., are members of the Arkansas State Medical Board. The State Medical Board is responsible for licensing medical professionals under Arkansas law. Ark. Code Ann. § 17–95–410. The Board and

its members are responsible for imposing licensing penalties under H.B. 1434 and H.B. 2024 and imposing licensing penalties for unprofessional conduct, which includes criminal conviction under statutes such as H.B. 1032, H.B. 1566, and H.B. 1434. Ark. Code Ann. §§ 75–95–409(a)(2)(A), (D). Defendants and their successors in office are sued in their official capacity.

(Dkt. No. 1, at 4–5, ¶¶ 14, 15). Therefore, defendants can be sued for prospective injunctive and declaratory relief in this action, as they have " 'some connection with the enforcement of the act.' " *Digital Recognition Network, Inc.*, 803 F.3d at 960 (citing *Ex Parte Young*, 209 U.S. at 157, 28 S.Ct. 441).

III. Facial Versus As-Applied Challenges

*16 **[14]** **[15]** Dr. Hopkins brings both facial and as-applied challenges to certain of these Mandates. In regard to facial challenges in general, the majority of courts have adopted a definition of facial challenges as those seeking to have a statute declared unconstitutional in all possible applications. *See, e.g., Sabri v. United States*, 541 U.S. 600, 609, 124 S.Ct. 1941, 158 L.Ed.2d 891 (2004); *United States v. Salerno*, 481 U.S. 739, 745, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987); *Steffel*, 415 U.S. at 474, 94 S.Ct. 1209. As-applied challenges are construed as an argument that the statute is unconstitutional as applied to precise plaintiffs. "Each holding carries an important difference in terms of outcome: If a statute is unconstitutional as applied, the State may continue to enforce the statute in different circumstances where it is not unconstitutional, but if a statute is unconstitutional on its face, the State may not enforce the statute under any circumstances." *See Women's Medical Professional Corp. v. Voinovich*, 130 F.3d 187, 193–94 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036, 118 S.Ct. 1347, 140 L.Ed.2d 496 (1998).

The Supreme Court has made clear that as-applied challenges are preferred. *See Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 448–451, 128 S.Ct. 1184, 170 L.Ed.2d 151 (2008) (discussing the preference for as-applied challenges as opposed to facial challenges). In *Salerno*, the Supreme Court stated that a "facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully" and will only succeed if a litigant can "establish that no set of circumstances exists under which the Act would be valid." 481 U.S. at 745, 107 S.Ct. 2095.

[16] The standard that controls a facial challenge to an abortion statute is somewhat different than that applicable to facial challenges in general. The Eighth Circuit Court of Appeals has recognized that facial challenges to abortion statutes can succeed only if a plaintiff can show that "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791. *See also Planned Parenthood Minn., N.D., S.D. v. Rounds*, 653 F.3d 662, 667–68 (8th Cir. 2011), *vacated in part on reh'g en banc sub nom. Planned Parenthood Minn., N.D., S.D. v. Rounds*, 662 F.3d 1072 (8th Cir. 2011) and *in part on reh'g en banc sub nom. Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889 (8th Cir. 2012); *see also Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 733 n.8 (8th Cir. 2008) ("*Rounds* cases"). In ***Whole Woman's Health***, the Supreme Court clarified that "cases in which the provision at issue is relevant" is a narrower category than "all women," "pregnant women," or even "*women seeking abortions* identified by the State." 136 S.Ct. at 2320 (quoting *Casey*, 505 U.S. at 895–95, 112 S.Ct. 2791). To sustain a facial challenge and grant a preliminary injunction, this Court must find that the challenged Mandate is an undue burden for a large fraction of women "for whom the provision is an actual rather than an irrelevant restriction." *See id.* (discussing this as the "relevant denominator").

The Eighth Circuit Court of Appeals recognizes that "the 'large fraction' standard is in some ways 'more conceptual than mathematical,' " but this Court is required by controlling precedent to conduct this fact finding "to determine whether that number constitutes a 'large fraction.' " *Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley*, No. 16–2234, — F.3d ——, ——, 2017 WL 3197613, *5 (8th Cir. July 28, 2017) (citing *Cincinnati Women's Servs., Inc. v. Taft*, 468 F.3d 361, 374 (6th Cir. 2006)).

To the extent defendants argue that a different legal standard should apply to facial challenges to abortion statutes, the Court rejects the argument. The Eighth Circuit's decisions control this Court's decisions, and the Eighth Circuit has applied this same standard to a facial challenge to an abortion statute since the decision in *Gonzales*, 550 U.S. at 168, 127 S.Ct. 1610. *See Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley*,

No. 16–2234, — F.3d ——, ——, 2017 WL 3197613, *5 (8th Cir. July 28, 2017).

*17 "Traditionally, a plaintiff's burden in an as-applied challenge is different from that in a facial challenge. In an as-applied challenge, 'the plaintiff contends that application of the statute in the particular context in which he has acted, or in which he proposes to act, would be unconstitutional.' " *Voinovich*, 130 F.3d at 193–94 (quoting *Ada v. Guam Soc'y of Obstetricians and Gynecologists*, 506 U.S. 1011, 1012, 113 S.Ct. 633, 121 L.Ed.2d 564 (1992) (Scalia, J., dissenting), *denying cert. to* 962 F.2d 1366 (9th Cir. 1992)). "Therefore, the constitutional inquiry in an as-applied challenge is limited to the plaintiff's particular situation." *Voinovich*, 130 F.3d at 193–94.

IV. Requests For Preliminary Injunctions

[17] The Court turns to examine the factors set forth in *Dataphase Systems, Inc. v. C L Systems, Inc.*, as applied to Dr. Hopkins's requests for preliminary injunctive relief. 640 F.2d 109 (8th Cir. 1981). In deciding a preliminary injunction motion, the Court considers four factors: (1) the probability that the movant will succeed on the merits; (2) the threat of irreparable harm to the movant; (3) the balance of the equities; and (4) the public interest. *Grasso Enterprises, LLC v. Express Scripts, Inc.*, 809 F.3d 1033, 1035 n.2 (8th Cir. 2016) (citing *Dataphase*, 640 F.2d at 114). Under *Dataphase*, no one factor is determinative. *Id.* at 113.

[18] The Eighth Circuit modifies the *Dataphase* test when applied to challenges to laws passed through the democratic process. Those laws are entitled to a "higher degree of deference." *Rounds*, 530 F.3d at 732. In such cases, it is never sufficient for the moving party to establish that there is a "fair chance" of success. Instead, the appropriate standard, and threshold showing that must be made by the movant, is "likely to prevail on the merits." *Id.* Only if the movant has demonstrated that it is likely to prevail on the merits should the Court consider the remaining factors. *Id.* The Court will examine Dr. Hopkins's argument with respect to each of the four challenged laws.

A. The D & E Mandate (Count 1 Based On H.B. 1032, Act 45)

The Court examines whether it should preliminarily enjoin enforcement of the D & E Mandate, which imposes civil liability and a criminal penalty on physicians who "purposely perform or attempt to perform a dismemberment abortion and thereby kill an unborn child unless it is necessary to prevent a serious health risk to the pregnant woman." Ark. Code Ann. § 20–16–1803(a). Dr. Hopkins seeks a preliminary injunction based on count one of his complaint, which alleges that the D & E Mandate violates the Due Process Clause of the United States Constitution by placing an undue burden on Dr. Hopkins's patients' rights to liberty and privacy. This is a facial challenge.

Under the D & E Mandate, "purposely" is defined as acting "with purpose with respect to a material element of an offense" when, "[i]f the element involves the nature of the conduct of the actor or a result of the conduct of the actor, it is the conscious object of the actor to engage in conduct of that nature or cause such a result," and "[i]f the element involves the attendant circumstances, the actor is aware of the existence of such circumstances." Ark. Code Ann. § 20–16–1802(5).

"Attempt to perform or induce an abortion" is defined as "an act or omission of a statutorily required act, that under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion in this state in violation of this subchapter...." Ark. Code Ann. § 20–16–1802(2).

*18 "Dismemberment abortion" is defined as "an abortion performed with the purpose of causing the death of an unborn child that purposely dismembers the living unborn child and extracts one (1) piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or similar instruments that, through the convergence of two (2) rigid levers, slice, crush, or grasp a portion of the body of the unborn child to cut or tear off a portion of the body of the unborn child." Ark. Code Ann. § 20–16–1802(3)(A)(i). It includes "an abortion in which suction is used to extract the body of the unborn child subsequent to the dismemberment of the unborn child...." Ark. Code Ann. § 20–16–1802(3)(A)(ii). It does

not include "an abortion that uses suction to dismember the body parts of the unborn child into a collection container." Ark. Code Ann. § 20–16–1802(3)(B).

"Unborn child" is defined by the Arkansas legislature as "an individual organism of the species Homo sapiens from fertilization until live birth...." Ark. Code Ann. § 20–16–1802(7).

"Woman" is defined as "a female human being whether or not she has reached the age of majority." Ark. Code Ann. § 20–16–1802(8). "Serious health risk to the pregnant woman" is defined as "a condition that, in a reasonable medical judgment, complicates the medical condition of a pregnant woman to such an extent that the abortion of a pregnancy is necessary to avert, either the death of the pregnant woman or the serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman." Ark. Code Ann. § 20–16–1802(6)(A). It does not include a psychological or emotional condition or "a medical diagnosis that is based on a claim of the pregnant woman or on a presumption that the pregnant woman will engage in conduct that could result in her death or that could cause substantial and irreversible physical impairment of a major bodily function of the pregnant woman." Ark. Code Ann. § 20–16–1802(7)(B)(i)-(ii).

If a physician violates the D & E Mandate, the law imposes civil liability, Ark. Code Ann. § 20–16–1804, as well as the criminal penalties of a Class D felony under Arkansas law, Ark. Code Ann. § 20–16–1805.

Dr. Hopkins asserts that, if the D & E Mandate goes into effect, he will stop performing standard D & E abortions altogether due to ethical and legal concerns regarding compliance with the law, thereby rendering abortions essentially unavailable in the State of Arkansas starting at 14.0 weeks LMP. The most common method of second trimester abortion is a method with instrumentation called standard D & E. This involves two steps: dilating the cervix, and then evacuating the uterus with instruments such as forceps. There are several ways to dilate the cervix (Dkt. No. 4, ¶ 17; Dkt. No. 5, ¶ 13).

Typically, during the early weeks of the second trimester of pregnancy, a doctor performing standard D & E uses a combination of medications that open the cervix and manual dilators; then, the same day, the doctor uses forceps to remove the fetus and other contents of the uterus. Because the fetus is larger than the opening of the cervix, the fetal tissue generally comes apart as the physician removes it through the cervix. The reason that the cervical opening is smaller than the fetal parts is that, in general, the doctor dilates only enough to allow the safe passage of instruments and fetal tissue through the cervix (Dkt. No. 4, ¶ 17–18; Dkt. No. 5, ¶ 14). In Arkansas and elsewhere, standard D & E typically is a one-day procedure from 14.0 to 17.6 weeks LMP (Dkt. No. 5, ¶ 15; Dkt. No. 6, ¶ 17). Due to Arkansas's state mandated counseling laws, this means that generally a woman would be required to make two trips to the clinic for abortion care from 14.0 to 17.6 weeks LMP.

***19** Later in the second trimester, larger instruments require wider cervical dilation. Although some physicians continue to provide standard D & E as a one-day procedure, starting at 18.0 to 20.0 weeks LMP, it is typical for doctors to add overnight osmotic dilation to the standard D & E protocol. In Arkansas, the standard D & E protocol changes in two ways starting at 18.0 weeks LMP for almost all patients (Dkt. No. 5, ¶ 20). First, in Arkansas, a woman at 18.0 weeks LMP receives overnight dilation. This means that the abortion procedure takes two days, rather than one (Dkt. No. 5, ¶ 20). Second, in Arkansas, at the time a woman at 18.0 weeks LMP has placed in her cervix the osmotic dilators, which is the day before the intended evacuation, the woman also receives an injection of digoxin through the vaginal wall. That injection of digoxin is into the fetus or, if not, into the amniotic fluid. With either method of injection, the digoxin may not work effectively (Dkt. No. 5, ¶ 20). The next day, in women 18.0 weeks or later LMP, if the digoxin has not caused fetal demise, Dr. Hopkins currently will take steps with his forceps, such as compressing fetal parts, to ensure fetal demise and to establish compliance with existing laws (Dkt. No. 5, ¶ 21).

Osmotic dilators are thin sticks of material that swell when they absorb moisture; when placed in a woman's cervix, they absorb moisture from the woman's body, expand slowly, and slowly dilate the cervix. Once dilation is sufficient, typically the next day, the doctor proceeds as in earlier standard D & Es, removing the fetus, generally in pieces because it is larger than the cervical opening (Dkt. No. 4, ¶ 17; Dkt. No. 5, ¶ 16). For patients of Little Rock Family Planning Services, they are required to spend that overnight within 30 minutes of the clinic so that the doctor

is available in the rare instance in which a patient has any problem (Dkt. No. 6, ¶ 18).

Given the requirements of Arkansas law regarding mandated state counseling, for patients receiving abortion care at 18.0 to 21.6 weeks LMP, the law requires at least three trips to the clinic (Dkt. No. 6, ¶ 7). Starting at 18.0 to 22.0 weeks LMP, some physicians, including Dr. Hopkins, undertake an additional procedure to try to cause fetal demise before the evacuation phase of a D & E for most patients, meaning those for whom it is not contraindicated (Dkt. No. 5, ¶ 18).

Through the second trimester, standard D & E is a safe way to provide abortion in an outpatient setting, such as a family planning clinic (Dkt. No. 5, ¶ 17). The standard D & E procedure has a long-established safety record in this county, with major complications occurring in less than 1% of standard D & E procedures (Dkt. No. 4, ¶ 19).

1. Likelihood Of Success On The Merits

[19] **[20]** **[21]** To determine whether Dr. Hopkins is likely to succeed on his challenge to the D & E Mandate, this Court applies the undue burden standard. "A statute, which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." ***Whole Woman's Health***, 136 S.Ct. at 2309 (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)). Abortion regulations that "have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Id.* (quoting *Casey*, 505 U.S. at 878, 112 S.Ct. 2791 (plurality opinion)).

a. Applicable Law

[22] Federal constitutional protection of reproductive rights is based on the liberty interest derived from the due process clause of the Fourteenth Amendment. *Casey*, 505 U.S. at 846, 112 S.Ct. 2791 (majority opinion). Dr. Hopkins challenges the D & E Mandate on this basis. The United States Supreme Court, when recognizing this right, stated:

> We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.
>
> ***20** In addition, population growth, pollution, poverty, and racial overtones tend to complicate and not to simplify the problem.

Roe v. Wade, 410 U.S. 113, 116, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973).

Dr. Hopkins argues that, as a matter of Supreme Court precedent, defendants "cannot criminalize the performance of the most common method of abortion (and indeed the only method in Arkansas) in the second-trimester, pre-viability stage of pregnancy. *See Stenberg v. Carhart*, 530 U.S. 914, 945–46, 120 S.Ct. 2597, 147 L.Ed.2d 743 (2000); *accord Gonzales*, 550 U.S. at 150, 127 S.Ct. 1610; *Danforth*, 428 U.S. at 77–79, 96 S.Ct. 2831." (Dkt. No. 32, at 28). Dr. Hopkins further asserts that, "[t]his is exactly what the D & E Ban does, and it is unconstitutional... Decades of settled law holds that it is *per se* unconstitutional for the State to criminalize 'the ... dominant second-trimester abortion method.' *Gonzales*, 550 U.S. at 165, 127 S.Ct. 1610; *see also id.* at 150–54, 127 S.Ct. 1610; *Danforth*, 428 U.S. at 77–79, 96 S.Ct. 2831." (Dkt. No. 32, at 28). Defendants do not respond to this argument. The Court acknowledges this argument but concludes that, given the circumstances before it in this matter, an undue burden analysis of the D & E Mandate is warranted.

[23] Unless and until *Roe* is overruled by the United States Supreme Court, to determine whether a state statute is unconstitutional and violates substantive due process rights in this context, the Court applies the "undue burden" standard developed in *Casey*, 505 U.S. at 876–79, 112 S.Ct. 2791 (plurality opinion), and ***Whole Woman's Health***, 136 S.Ct. at 2309–11.

In *Casey*, a plurality of the Supreme Court determined that, if a government regulation has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus," the regulation is an undue burden on a woman's right to have an abortion and is unconstitutional. 505 U.S. at 877, 112 S.Ct. 2791. The Supreme Court recently reiterated the undue burden standard that "a statute which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." ***Whole Woman's Health***, 136 S.Ct. at 2309 (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)).

The Supreme Court in *Casey* recognized that a woman's right of privacy extends to the freedom "from unwarranted governmental intrusion so fundamentally affecting a person as the decision whether to bear or beget a child." 505 U.S. at 896, 112 S.Ct. 2791 (majority opinion) (quoting *Eisenstadt*, 405 U.S. at 453, 92 S.Ct. 1029). "Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause." 505 U.S. at 874, 112 S.Ct. 2791 (citations omitted). *See also Stenberg*, 530 U.S. at 930, 120 S.Ct. 2597; *Mazurek v. Armstrong*, 520 U.S. 968, 972–73, 117 S.Ct. 1865, 138 L.Ed.2d 162 (1997) (per curiam).

[24] **[25]** The undue burden analysis requires this Court to "consider the burdens a law imposes on abortion access together with the benefits those laws confer." ***Whole Woman's Health***, 136 S.Ct. at 2309. "An undue burden is an unconstitutional burden." *Casey*, 505 U.S. at 877, 112 S.Ct. 2791. In *Casey*, the Supreme Court described the "undue burden" test as follows: "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* The *Gonzales* Court then simplified *Casey*'s description, settling on the effects test. 550 U.S. at 158, 127 S.Ct. 1610. To show an undue burden, Dr. Hopkins must show that "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791. A court limits its inquiry to "the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* at 894, 112 S.Ct. 2791.

21** Defendants argue that the Supreme Court has created two distinct undue burden tests, depending on what interests the state seeks to regulate. Defendants contend that the balancing test of ***Whole Woman's Health applies only when "the state's interest is in... a patient's health or safety" and that the lesser standard of rational basis review applies "when a state regulates to promote respect for unborn life." (Dkt. No. 23, at 37). The Court rejects defendants' argument.

[26] At this stage, despite defendants' arguments to the contrary (Dkt. No. 23, at 38), the Court rejects rational basis review because this standard is inconsistent with controlling precedents that inform the nature of a woman's right to decide whether to continue a pregnancy or to abort a nonviable fetus. *See* ***Whole Woman's Health***, 136 S.Ct. at 2309–11; *Casey*, 505 U.S. at 834, 851, 112 S.Ct. 2791; *Lawrence v. Texas*, 539 U.S. 558, 565, 123 S.Ct. 2472, 156 L.Ed.2d 508 (2003) (determining that the right to abortion has "real and substantial protection as an exercise of [a woman's] liberty under the Due Process Clause"). In *Casey*, the Supreme Court examined state statutes purported to advance the state's interest in fetal life and applied the balancing test later cited in ***Whole Woman's Health***. Even in *Gonzales*, which defendants contend supports the use of rational basis review, the Supreme Court did not apply rational basis review to the challenged regulation. *See Gonzales*, 550 U.S. at 158, 160–161, 127 S.Ct. 1610.

[27] **[28]** **[29]** When applying the undue burden test, this Court must "weigh[ ] the asserted benefits against the burdens." ***Whole Woman's Health***, 136 S.Ct. at 2310. There must be "a constitutionally acceptable" reason for regulating abortion, and the abortion regulation must also actually advance that goal in a permissible way. *Id.* at 2309–10. The regulation will not be upheld unless the benefits it advances outweigh the burdens it imposes. *Id.* at 2310. "[T]he means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Casey*, 505 U.S. at 877, 112 S.Ct. 2791.

Defendants also argue that the Court should not engage in a balancing test when conducting the undue burden analysis (Dkt. No. 23, at 38–39). Defendants contend that, if the challenged provision survives the minimal rational basis scrutiny defendants advocate, the provision

may be struck only based on the effects and that, in evaluating these effects, the Court may not evaluate the strength of the asserted state interests against these effects. The Court rejects this argument. Other courts that have considered challenges to abortion restrictions based on the state's asserted interest in potential life since the Supreme Court issued its decision in ***Whole Woman's Health*** have applied the undue burden test, weighing the extent of the burden against the strength of the state's justification. *See Planned Parenthood of Ind. & Ky., Inc. v. Comm'r*, No. 1:16-cv-01807-TWP-DML, 2017 WL 1197308 (S.D. Ind. March 31, 2017) (applying undue burden balancing test to requirement that women delay abortion by 18 hours after obtaining an ultrasound premised in part on state's interest in promoting potential life), *appeal docketed*, No. 17–1883 (7th Cir. Apr. 27, 2017); ***Whole Woman's Health*** *v. Hellerstedt*, No. A-16-CA-1300-SS, —— F.Supp.3d ——, ——— – ———, 2017 WL 462400, at *7–8 (W.D. Tex. 2017) (applying undue burden test to tissue disposal regulations justified in part on state's interest in expressing respect for potential life), *appeal docketed*, No. 17–50154 (5th Cir. Mar. 1, 2017); *W. Ala. Women's Ctr. v. Miller*, 217 F.Supp.3d 1313, 1346–47 (M.D. Ala. 2016) (balancing benefits and burdens in assessing D & E ban justified as advancing the state's interest in respect for life), *appeal docketed*, No. 16–17296 (11th Cir. Nov. 26, 2016).

*22 [30] Further, under the applicable undue burden standard, although the Court must "review 'legislative fact finding under a deferential standard,' " ***Whole Woman's Health***, 136 S.Ct. at 2310, the court "retains an independent constitutional duty to review [a legislature's] factual findings where constitutional rights are at stake.... Uncritical deference to [the legislature's] factual findings in these cases is inappropriate." *Gonzales*, 550 U.S. at 165, 167, 127 S.Ct. 1610. See also ***Whole Woman's Health***, 136 S.Ct. at 2310.

[31] [32] Generally, the state has the burden of demonstrating a link between the legislation it enacts and what it contends are the state's interests. *See Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430, 103 S.Ct. 2481, 76 L.Ed.2d 687 (1983), *overruled on other grounds by Casey*, 505 U.S. 833, 112 S.Ct. 2791 (describing the burden as that of the state). As a part of the Court's inquiry, the Court may take into account the degree to which the restriction is over-inclusive or under-inclusive, *see, e.g.*, ***Whole Woman's Health***, 136 S.Ct. at 2315 (discussing over- and under-inclusive scope of the provision), and the existence of alternative, less burdensome means to achieve the state's goal, including whether the law more effectively advances the state's interest compared to prior law, *see, e.g.*, ***Whole Woman's Health***, 136 S.Ct. at 2311 (noting that prior state law was sufficient to serve asserted interest); *Id.* at 2314 ("The record contains nothing to suggest that [the challenged provisions] would be more effective than pre-existing [state] law at deterring wrongdoers... from criminal behavior.").

[33] Dr. Hopkins, who challenges the laws, retains the ultimate burden of proving their unconstitutionality. *Mazurek*, 520 U.S. at 972, 117 S.Ct. 1865 (reversing appellate court for enjoining abortion restriction where plaintiffs had not proven that the requirement imposed an undue burden); *Casey*, 505 U.S. at 884, 112 S.Ct. 2791 (affirming provision where "there is no evidence on this record" that the restriction would amount to an undue burden).

For Dr. Hopkins's challenges based on alleged violations of the Due Process Clause, the Court will begin its analysis of the merits by examining each provision and the asserted state justification for each provision. The Court will then examine the alleged undue burden of the provision, and the Court will make findings of fact regarding the fraction of women, if any, for whom the D & E Mandate imposes an undue burden.

b. Analysis Of The D & E Mandate

1. State's Interests

No legislative findings accompany the D & E Mandate. The Court does not have an explanation from the legislature of the purpose of the law. Defendants argue that the law advances the interests of regulating medical ethics and promoting respect for the life of an unborn child (Dkt. No. 22, at 20).[4] The Court assumes the legitimacy of these interests. ***Whole Woman's Health***, 136 S.Ct. at 2310 (assuming that the State had legitimate state interests where the statute did not contain any legislative findings).

2. Burdens Imposed On Women

Dr. Hopkins argues that, although the D & E Mandate does not use recognized medical terminology, it bans standard D & E because it criminalizes the use of surgical instruments to cause disarticulation or, in the D & E Mandate's terms, "dismemberment" of a "living" fetus. Ark. Code Ann. § 20–16–1802(3) (2017). He asserts that the law would force Arkansas women seeking pre-viability abortions to undergo medically unnecessary procedures and subject women to increased health risks. Dr. Hopkins also asserts that, if the D & E Mandate goes into effect, standard D & E abortions essentially will become unavailable in the State of Arkansas starting at 14.0 weeks LMP due to ethical and legal concerns regarding compliance with the law.

***23** He maintains that the D & E Mandate "would constitute a significant step backward...." (Dkt. No. 3, at 6). Standard D & E was a significant advance over earlier methods of second trimester abortion (Dkt. No. 4, ¶ 19). *See also City of Akron*, 462 U.S. at 435–36, 103 S.Ct. 2481, *overruled in part on other grounds by Casey*, 505 U.S. 833, 112 S.Ct. 2791 ("Since [*Roe v. Wade* was decided], the safety of second trimester abortions has increased dramatically. The principal reason is that the D & E procedure is now widely and successfully used....") (footnotes omitted).

Starting in the early second trimester, standard D & E is the only procedure that can be performed on an outpatient, ambulatory basis (Dkt. No. 4 ¶ 14; Hopkins 17). *See also City of Akron*, 462 U.S. at 436, 103 S.Ct. 2481. This significantly reduces the expense of a second trimester abortion (Dkt. No. 4, ¶ 14).

The alternative to standard D & E is an induction procedure, in which physicians use medication to induce labor and delivery of a non-viable fetus (Dkt. No. 4, ¶ 14). Induction must be performed at a facility such as a hospital, not in an outpatient setting, and the patient may be kept for an extended stay because an induction may take 5 hours to 3 days to complete, not the 10 to 15 minutes it takes to complete a standard D & E (Dkt. No. 4, ¶ 14; Dkt. No. 5, ¶ 12). Induction requires a woman to go through labor, which is painful, psychologically challenging for some women, and medically contraindicated for some women (Dkt. No. 4, ¶ 14, Dkt. No. 5, ¶1 2).

If the D & E Mandate were to take effect, Dr. Hopkins asserts that he would stop performing abortions at approximately 14.0 weeks LMP because, after that point, he would not know whether he would be able to ensure fetal demise before taking actions banned under the D & E Mandate (Dkt. No. 3, at 7; Dkt. No. 5, ¶¶ 23, 26). Under the D & E Mandate, the only D & E that would be legal is one in which a physician successfully induces fetal demise through an additional procedure prior to starting the evacuation phase of D & E (Dkt. No. 3, at 7). Dr. Hopkins claims that, because it is not feasible or safe for him to induce fetal demise through an additional procedure in every patient prior to starting the evacuation phase of D & E, he would not start any D & E because he may not be able to complete the procedure without violating the D & E Mandate (Dkt. No. 3, at 7).

Defendants respond that fetal demise can be achieved before standard D & E with one of three procedures: digoxin injections, potassium chloride injections, and umbilical cord transection.[5] The Court's determination whether the D & E Mandate imposes substantial obstacles to abortion access depends on the feasibility of defendants' proposed fetal demise methods. For the following reasons, the Court rejects each of defendants' proposed fetal demise methods.

To the extent defendants contend that this Court is barred from evaluating the medical evidence concerning both the feasibility and safety of defendants' proposed fetal demise methods, the Court rejects this argument (Dkt. No. 23, at 45–46). Defendants contend that medical disagreement or uncertainty over the impact of the D & E Mandate is for resolution by the legislature alone (*Id.*). The Court disagrees. As an initial matter, the Court is unconvinced at this stage, based on the record evidence now before it, that defendants' evidence creates a medical disagreement or uncertainty. Even if it does, as the Supreme Court acknowledged in *Casey*, "[i]t is conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other.... That theorem, however, assumes a state of affairs in which the choice does not intrude upon a protected liberty." 505 U.S. at 851, 112 S.Ct. 2791. There is a protected liberty interest at stake here. In ***Whole Woman's Health***, the Supreme Court rejected a similar argument, holding that the "statement that legislatures, and not courts, must resolve questions of medical uncertainty is... inconsistent with this Court's case

law." 136 S.Ct. at 2310. For these reasons, this Court does not accept at this stage defendants' argument regarding medical disagreement.

a. Digoxin Injection

*24 When examining digoxin injections, it is important to distinguish between injections before 18.0 weeks LMP and those after 18.0 weeks LMP, based on the record before the Court. Dr. Hopkins asserts that there is no reasonable or accepted procedure available for a physician providing standard D & E even to attempt fetal demise in a way that might avoid the ban before 18.0 weeks LMP (Dkt. No. 4, ¶ 36; Dkt. No. 5, ¶ 24). He maintains that all methods proposed by defendants for inducing fetal demise before standard D & E, including digoxin injection before 18.0 weeks LMP, are virtually untested, have unknown risks and uncertain efficacy, and would be outside the standard of care (Dkt. No. 4, ¶ 26; Dkt. No. 5, ¶¶ 25–26). Any attempts to cause fetal demise prior to 18.0 weeks LMP would mean experimentation and imposing risks with no medical benefit, according to Dr. Hopkins (Dkt. No. 3, at 8).

Starting at 18.0 weeks LMP, during the latter part of the second trimester, a majority of physicians who attempt to induce fetal demise, including Dr. Hopkins and other physicians at Little Rock Family Planning Services, do so by injecting digoxin either transabdominally or transvaginally (Dkt. No. 4, ¶ 21; Dkt. No. 5, ¶ 25). Usually, physicians using these injections, including Dr. Hopkins, do so to comply with the federal "partial birth abortion ban" and similar state laws (Dkt. No. 4, ¶ 23; Dkt. No. 5, ¶ 19). *See* 18 U.S.C. 1531; Ark. Code Ann. 20–16–1203 (2009). Doing so confers no medical benefit for the woman, as the American College of Obstetricians and Gynecologists ("ACOG") has stated: " 'No evidence currently supports the use of induced fetal demise to increase the safety of second trimester medical or surgical abortion.' " (Dkt. No. 4, ¶ 22)(quoting Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin Number 135: Second Trimester Abortion, 121(6) Obstetrics & Gynecology 1394, 1396, 1406 (2013)).

Dr. Hopkins maintains that this practice does not save the D & E Mandate even for those patients post–18.0 weeks LMP. First, he maintains digoxin injections are not possible for every patient due to anatomical characteristics which may contraindicate these injections (Dkt. No. 3, at 9). Second, in some cases, digoxin fails to cause fetal demise, and Dr. Hopkins or any other physician cannot know before starting a procedure the patients in whom it will fail (Dkt. No. 4, ¶ 28; Dkt. No. 5, ¶ 25c). Dr. Hopkins maintains the proper course when digoxin fails is to complete the abortion without additional delay (Dkt. No. 4, ¶ 29; Dkt. No. 5, ¶ 25d).

If digoxin does not result in fetal demise after 24 hours, the D & E Mandate could be read to compel a physician to attempt a second injection of digoxin, which is untested and contrary to the standard of care (Dkt. No. 4, ¶ 29; Dkt. No. 5, ¶ 25b). According to Dr. Hopkins, administering a second dose of digoxin and waiting an undetermined amount of time for fetal demise, rather than completing the abortion, would put a patient who is already dilated and whose uterus may have already started to contract at risk of infection or delivery outside the clinic (Dkt. No. 4, ¶ 29; Dkt. No. 5, ¶ 25b).

Dr. Hopkins would not feel comfortable asserting that those risks, while real and unacceptable, rise to the very high level of the D & E Mandate's narrow exception, limited to circumstances "necessary to avert either... death... or the serious risk of substantial and irreversible physical impairment of a majority of bodily function." 20–16–1802(6)(A)—1803(a). He forms this opinion based on his experience (Dkt. No. 5, ¶ 25f).

In sum, Dr. Hopkins maintains that he would end standard D & E practice if the D & E Mandate takes effect because, although he is a highly trained and experienced obstetrician-gynecologist, and can attempt digoxin injections to try to cause fetal demise in most patients beginning at 18.0 weeks LMP, he will not experiment on patients by attempting injections earlier than 18.0 weeks LMP, will not do injections when medically contraindicated, will not do a second injection if the first one fails, and will not start a procedure when he does not know whether he will be able to finish it without violating the ban (Dkt. No. 5, ¶ 24). This would end standard D & E practice starting at 14.0 weeks LMP, which represents 100% of abortion care during that period reported in Arkansas in 2015 (Dkt. No. 4, ¶ 38; Dkt. No. 5, ¶ 23).

*25 The Court concludes that digoxin injections are not a feasible method of causing fetal demise before a

standard D & E. Digoxin injections are experimental for women before 18.0 weeks LMP, and most second trimester abortions in Arkansas are performed before 18.0 weeks LMP. There is no record evidence of any physician attempting digoxin injections earlier than 18.0 weeks LMP (Dkt. No. 4, ¶ 25). There are virtually no reported studies, and no studies of record, on using digoxin in the first weeks of the second trimester, when most second trimester abortions are performed (Dkt. No. 4, ¶ 26; Dkt. No. 32–3, Biggio Cross, at 143–44). Requiring digoxin injections for every patient starting at 14.0 weeks LMP would be requiring a physician to experiment on his patient, without any way to know or counsel her on the effectiveness or safety of the experiment (Dkt. No. 32–1, ¶ 9; Dkt. No. 5, ¶ 24).

Of the physicians who undertake an additional procedure after 18.0 to 22.0 weeks LMP, the vast majority of physicians inject the drug digoxin into the fetus if possible or, if not, then into the amniotic fluid. Injecting digoxin into the amniotic fluid is technically easier, but it is less effective (Dkt. No. 4, ¶ 21; Dkt. No. 5, ¶ 18). The injections may be through the woman's abdomen or vaginal wall. These injections generally use an 18– to 22–gauge spinal needle, passed under ultrasound guidance, through the patient's abdomen, vaginal wall, or vagina and cervix, and then either into the amniotic fluid or the fetus (Dkt. No. 4, ¶ 21, 25; Dkt. No. 5, ¶ 18).

There are some women for whom an injection of digoxin may be difficult or impossible. For example, woman may be very obese; may have anatomical variations of the uterine and vaginal anatomy, such as fibroids or a long cervix; and may have fetal positioning that creates issues. These injections also can be dangerous for women with cardiac conditions such as arrhythmias (Dkt. No. 4, ¶ 27). Even for women who tolerate injections, digoxin will not cause fetal demise in 5% to 10% of all cases in which it is used (Dkt. No. 4, ¶ 28).

The failure rate is higher for intramniotic injections. Intramniotic injections are associated with higher complication rates than intrafetal injection (Dkt. No. 4, ¶ 25). Intrafetal injections are more difficult to perform and may be impossible to perform due to fetal position, uterine anatomy and other factors, especially the size of the fetus. The smaller the fetus, the more difficult intrafetal injection will be (Dkt. No. 4, ¶ 28).

Digoxin works very slowly. Doctors allow 24 hours after the injection for it to work. Even then, it does not always cause fetal demise (Dkt. No. 5, ¶ 18). There is record evidence that the transabdominal injection can be painful and emotionally difficult for the patient. The injection poses risks, including infection, which can threaten the patient's health and future fertility, and accidental absorption of the drug into the patient's circulation, which can result in toxicity and changes to the patient's EKG (Dkt. No. 4, ¶ 25).

Like all medical procedures, the digoxin injection creates risks for the patient. Doctors who use digoxin believe that practical concerns justify using it. The record evidence is that the main benefit of using digoxin is to establish compliance with the federal "partial-birth abortion ban" or similar state laws (Dkt. No. 4, ¶ 23; Dkt. No. 5, ¶ 19). The federal "partial-birth abortion ban" has an intent requirement (Dkt. No. 4, ¶ 23).

Based on the record before the Court there are no reported studies of record on using a second injection of digoxin, or multiple, sequential injections of digoxin, after the first dose fails to bring about fetal demise (Dkt. No. 4, ¶ 29). Using a second injection of digoxin would, at a minimum, delay the abortion procedure, require the patient to make another trip to the clinic, and increase the risk of uterine infection, extramural delivery, or digoxin toxicity (Dkt. No. 4, ¶ 29).

***26** Utilizing a digoxin injection to induce fetal-demise would impose additional logistical obstacles to abortion access. Women undergoing digoxin injections would be required to make an additional trip to the clinic 24 hours prior to their D & E procedure appointment. *See Whole Woman's Health*, 136 S.Ct. at 2313 (external factors that affect women's ability to access abortion care—such as increased driving distance—should be considered as an additional burden when conducting the undue burden analysis). If digoxin injections were used to induce fetal demise, a woman seeking an abortion would have to meet with a physician at least three times over a minimum of four days for a 10 to 15 minute procedure. First, she would have to receive the counseling mandated by Arkansas law. Second, she would have to return for the digoxin injection. Third, she would have to return after 24 hours for the physician to determine whether fetal demise was achieved. If fetal demise was achieved, the D & E could proceed.

However, in 5% to 10% of cases, the first digoxin injection will fail. As a result, additional visits could be required.

The burden of having to make multiple trips for the procedure is especially pronounced for low-income women. The procedure would become time and cost-prohibitive for some women. Faced with this financial and logistical burden, some low income women may delay obtaining an abortion or not have an abortion at all. Many patients of Little Rock Family Planning Services are low-income. Approximately 30 to 40% of patients obtain financial assistance to pay for their abortion care (Dkt. No. 6, ¶ 5). Many patients of Little Rock Family Planning Services struggle in their lives and in their efforts to access the medical care they need (Dkt. No. 6, ¶ 5). The time and effort it takes to make the necessary plans to access medical care cause anxiety and stress and cause financial pressure for women seeking care at Little Rock Family Planning Services. Women must arrange for time off work on multiple days, which can be very difficult given that many are in low-wage jobs and feel that they cannot explain to an employer the reason they need to take time off. For women who already have children, these women must arrange and often pay for childcare. These women also must arrange and pay for transportation. In some cases, these women also have to arrange and pay for a place to stay for multiple nights (Dkt. No. 6, ¶ 8).

Due to the unreliability of the procedure, unknown risks for women before 18.0 weeks LMP, unknown risks associated with injection of a second dose of digoxin if the first fails, increased risks of complications, increased travel burden, and pain and invasiveness of the procedure, the Court concludes that a digoxin injection is not a feasible method of inducing fetal demise before standard D & E in Arkansas.

b. Potassium Chloride Injection

Another substance, potassium chloride (KCl), will cause fetal demise if injected directly into the fetal heart, which is extremely small (Dkt. No. 4, ¶ 31; Dkt. No. 5, ¶ 22). The record evidence is, and there is no credible dispute, that the procedure of injecting potassium chloride is very rare, as it carries much more severe risks for the woman, including death if the doctor places the solution in the wrong place (Dkt. No. 4, ¶ 31; Dkt. No. 5, ¶ 22; Dkt. No. 32–2, ¶ 3; Dkt. No. 32–3, Biggio Direct, at 111, Biggio Cross, at 140–41). The procedure requires extensive training generally available only to sub-specialists in high-risk obstetrics, known as maternal-fetal medicine (Dkt. No. 4, ¶ 31; Dkt. No. 5, ¶ 22; Dkt. No. 32–2, ¶ 3; Dkt. No. 32–3, Biggio Direct, at 111, Biggio Cross, at 140–41). Dr. Hopkins and the other doctors with whom he practices at Little Rock Family Planning Services, like the vast majority of obstetrician-gynecologists, do not have this specialized training (Dkt. No. 4, ¶ 31; Dkt. No. 5, ¶ 22). Contrary to defendants' suggestion, the Court is unaware of any authority, including in *Gonzales*, that requires Dr. Hopkins to undertake years of training in the subspecialty of maternal fetal medicine to perform abortions (Dkt. No. 23, at 43 (citing *Gonzales*, 550 U.S. at 163, 127 S.Ct. 1610)).

27** Further, injecting potassium chloride is usually done in a hospital, not a clinical, setting. The procedure requires an advanced ultrasound machine that is typically available only in a hospital setting and too expensive for most clinics to afford (Dkt. No. 4, ¶ 31; Dkt. No. 32–2, ¶ 3; Dkt. No. 32–3, Biggio Direct, at 111, Biggio Cross, at 140–41). Defendants cite no legal or record support for their argument that Dr. Hopkins or Little Rock Family Planning Services can be required to obtain, or could obtain, such equipment without unduly burdening women who seek abortion (Dkt. No. 23, at 43). *See **Whole Woman's Health, 136 S.Ct. at 2318 (examining, in the undue burden context, the costs a current abortion facility would have to incur to meet the regulation's requirements). The cost also would be prohibitive for women who seek abortion. *See Causeway Med. Suite v. Foster*, 43 F.Supp.2d 604, 612–13 (E.D. La. 1999) (a ban on "surgical abortion" unless "fetal demise is first induced" imposes an undue burden because it "may force women seeking abortions to accept riskier or costlier abortion procedures."). Further, defendants cite no legal or record support for their suggestion that over 600 patients seeking a standard D & E each year in Arkansas could go to an Arkansas hospital for a potassium chloride injection to terminate their second-trimester pregnancies, equating roughly to 12 patients per week (Dkt. No. 23, at 43).

There also are some women for whom injecting potassium chloride is not medically appropriate (Dkt. No. 4, ¶ 31). Obesity, fetal and uterine positioning, and presence of uterine fibroids may complicate or prevent the administration of these injections.

The Court concludes that potassium chloride injections are not a feasible method of inducing fetal demise before standard D & E procedures. Injecting potassium chloride takes specialized training, and Dr. Hopkins lacks that specialized training. The only subspecialists who are trained to perform the injections are maternal-fetal medicine fellows who go through highly supervised training to specialize in high-risk pregnancies. Further, Dr. Hopkins lacks the costly equipment necessary to perform the procedure on an outpatient basis.

Potassium chloride injections are an unnecessary and potentially harmful medical procedure with no counterbalancing medical benefit for the patient. It is a technically challenging procedure that carries serious health risks. For all of these reasons, the Court determines potassium chloride injections are an unavailable method for fetal demise for women seeking a standard D & E abortion in the state of Arkansas.

c. Umbilical Cord Transection [6]

Umbilical cord transection involves the physician rupturing the membranes, inserting a suction tube or other instrument such as forceps into the uterus, and grasping the cord, if possible, to divide it with gentle traction, which will cause demise over the course of up to 10 minutes (Dkt. No. 4, ¶ 32). The success and ease of this procedure depends on placement of the umbilical cord. If the umbilical cord is blocked by the fetus, it would be very difficult and very risky to attempt to reach it (Dkt. No. 4, ¶ 33).

The record evidence is that umbilical cord transection is not widely practiced or researched (Dkt. No. 4, ¶ 32). There has been only one scientific study on the use of cord transection to cause fetal demise; the physicians relied upon by the parties agree on this (Dkt. No. 32–1, ¶ 11; Dkt. No. 32–3, Biggio Cross, at 146). The one scientific study on the use of cord transection has limitations and does not support any conclusion about the safety of the procedure (Dkt. No. 32–1, ¶¶ 12–13).

Attempting umbilical cord transection before 16.0 weeks LMP is completely unstudied, and like injections, these procedures are more difficult to perform the earlier in pregnancy a woman seeks care. Successfully identifying and transecting the cord at early gestations would take additional time and likely multiple passes with forceps (Dkt. No. 32–1, ¶¶ 14–15).

***28** Further, this procedure exposes the woman to an increased risk of uterine perforation, cervical injury, and bleeding, while it unnecessarily prolongs the D & E procedure (Dkt. No. 4, ¶¶ 32–34). The record evidence is that the longer a D & E takes and the more instruments passes into the woman's uterus occur, the higher the risks of uterine perforation and other complications; physicians relied upon by both sides agree on this (Dkt. No. 4, ¶¶ 32–34; Dkt. No. 5, ¶ 25d; Dkt. No. 32–1, ¶¶ 13, 15; Dkt. No. 23–15, ¶ 8; Dkt. No. 32–3, Biggio Cross, at 144–45; Dkt. No. 25–4, ¶ 6).

There are some women for whom umbilical cord transection is not medically appropriate; physicians relied upon by both sides agree on this (Dkt. No. 4, ¶ 32; Dkt. No. 23–15, ¶ 12).

In seeking to grasp the umbilical cord, physicians will often have no way to avoid grasping fetal tissue instead of, or in addition to, the cord. Doing so would violate the D & E Mandate, according to Dr. Hopkins, and umbilical cord transection provides no way to circumvent the D & E Mandate (Dkt. No. 4, ¶ 35; Dkt. No. 5, ¶¶ 25d–25e).

Dr. Nichols, an expert upon whom Dr. Hopkins relies, does not perform umbilical cord transection (Dkt. No. 4, ¶¶ 32–35; Dkt. No. 32–1, ¶¶ 11–15). No physician to which either party cites would require cord transection in their respective practices (Dkt. No. 4, ¶ 34; Dkt. No. 5, ¶ 25d; Dkt. No. 32–3, Biggio Cross, at 144).

This essentially is an experimental procedure that provides no medical benefits to the woman. The Court concludes that because this procedure is difficult, because this procedure has the potential for serious harm, and due to the lack of sufficient research on the procedure, umbilical cord transection is an unavailable method for fetal demise for women seeking a standard D & E abortion in the state of Arkansas.

For all three of these methods—digoxin, potassium chloride injections, and umbilical cord transection—no evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion. This is consistent with the medical

literature (Dkt. No. 4, ¶ 22; Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin Number 135: Second Trimester Abortion, 121(6) Obstetrics & Gynecology 1394, 1396, 1406 (2013)).

3. Balancing

In ***Whole Woman's Health***, the Supreme Court clarified that the undue burden analysis "requires that courts considers the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S.Ct. at 2309. The Supreme Court has determined that, to prevail, a plaintiff bringing a facial challenge must demonstrate that "in a large fraction of cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791. The Court assumes the State of Arkansas's interests are legitimate. The State of Arkansas maintains that its interests are sufficiently strong to justify the burdens the D & E Mandate would impose because, even with the Mandate, women would retain the ability to terminate pregnancy at or after 14.0 weeks LMP.

Defendants' argument is premised on it being feasible for Dr. Hopkins to utilize one of the three fetal-demise methods examined above: digoxin injection, potassium chloride injection, or umbilical cord transection. For the reasons discussed above, the Court concludes that on the current record these proposed methods are not feasible for inducing fetal demise before the standard D & E procedure Dr. Hopkins and other Arkansas abortion providers perform. *Danforth*, 428 U.S. at 79, 96 S.Ct. 2831 (striking down an abortion method ban where the alternatives proposed by the state were largely experimental and unavailable to women in the state). Therefore, the Court concludes that the D & E Mandate does not "confer[ ] benefits sufficient to justify the burdens upon access that [it] imposes." ***Whole Woman's Health***, 136 S.Ct. at 2299.

29** This Court concludes that, whether this Court weighs the asserted state interests against the effects of the provisions or examines only the effects of the provisions, Dr. Hopkins has carried his burden of demonstrating at this stage of the litigation that he is likely to prevail on the merits and to establish that the challenged D & E Mandate creates an undue burden for a large fraction of women for whom the D & E Mandate is an actual rather than an irrelevant restriction. The record includes sufficient evidence from which Dr. Hopkins satisfies his burden to present evidence of causation that the Mandate's requirements will lead to this effect. *See* ***Whole Woman's Health, 136 S.Ct. at 2313.

Further, the Court rejects defendants' other attempts to salvage the constitutionality of the D & E Mandate. Specifically, for the following reasons, the Court rejects defendants' arguments premised on a scienter requirement in the D & E Mandate and the health exception in the D & E Mandate.

a. Scienter Requirement

Defendants maintain that there is a scienter requirement in the D & E Mandate, relying on language that prohibits a person from "purposely performing" a dismemberment abortion, meaning that it is one's "conscious object... to engage in conduct of that nature." (Dkt. No. 23, at 9 n.4). Defendants essentially contend that this scienter requirement preserves access to D & E, thereby rendering the D & E Mandate constitutional. The Court rejects this argument.

There is record evidence that physicians use digoxin to demonstrate a lack of *mens rea* and thereby avoid liability under the federal and similar state partial-birth abortion bans. *See* 18 U.S.C. § 1531(b)(1)(A) (prohibiting a person's acting "deliberately and intentionally... for the purpose of performing an overt act that the person knows will kill the... fetus."); Ark. Code Ann. § 20–16–1202 (prohibiting a person's acting "purposely... for the purpose of performing an overt act that the person knows will kill the... fetus."). From this, defendants maintain that Dr. Hopkins could comply with the D & E Mandate by injecting women with digoxin before 18.0 weeks LMP, regardless of the effectiveness of those injections because the injection alone would be enough to negate the scienter requirement of the D & E Mandate.

The Court makes no determination on whether the D & E Mandate includes the type of scienter requirement defendants claim. [7] The Court also makes no determination regarding the scope or contours of such a requirement. [8] Even if the D & E Mandate does include the scienter requirement defendants advocate there is no record evidence that demonstrates the safety or reliability

of injecting women with digoxin earlier than 18.0 weeks LMP. In other words, concluding that the D & E Mandate has a scienter requirement would not resolve this dispute regarding the safety and reliability of using digoxin in D & E procedures before 18.0 weeks LMP. It also would not resolve the safety and feasibility issues associated with potassium chloride injections. Those disputes remain and render digoxin injections before 18.0 weeks LMP and potassium chloride injections not feasible alternatives, even with a scienter requirement.

*30 Moreover, such a scienter requirement also would not save the method of umbilical cord transection for different reasons. Defendants maintain that the scienter requirement allows for separation of fetal tissue if the physician is using forceps to try to grasp and transect the cord (Dkt. No. 23, at 44–45). Dr. Hopkins convincingly argues that this ignores the fact that the experts relied upon by both sides agree that a physician knows that in attempting to reach for the cord, he is likely to grasp fetal tissue instead of or in addition to the cord (Dkt. No. 4, ¶ 35; Dkt. No. 5, ¶ 25e; Dkt. No. 32–3, Biggio Direct, at 125). There is some evidence that the earlier in pregnancy a woman seeks care, the more likely this is to happen (Dkt. No. 32–1, ¶ 15). Having this knowledge, Dr. Hopkins maintains a physician cannot proceed to perform a D & E by umbilical transection and credibly maintain that he did not purposely violate the D & E Mandate, given the law's defined terms and the inability to avoid prosecution through willful blindness. This Court, at this stage of the proceedings, finds Dr. Hopkins arguments on this point persuasive (Dkt. No. 32, at 42–43).

b. Health Exception

The Court rejects defendants' argument that "women who need [a D & E] for medical reasons" would still be able to obtain one (Dkt. No. 23, at 45). There is no record evidence to support this assertion. Instead, the record evidence supports Dr. Hopkins's argument that the health exception is narrow and does not justify defendants' assertion. Dr. Hopkins maintains that a woman who is already dilated and for whom digoxin has failed needs an abortion "for medical reasons" but that care is not yet "necessary to avert" her "death" or "serious risk of substantial and irreversible" physical harm (Dkt. No. 4, ¶ 25f). The D & E Mandate, even with its health exception, would require that a woman be denied a D & E abortion until her health condition substantially and inevitably deteriorated (Dkt. No. 4, ¶ 25f). Further, as Dr. Hopkins argues, the health exception also does not provide an exception for any woman for whom the other fetal demise methods offered by defendants are difficult or impossible because of anatomy or medical contraindication (Dkt. No. 32, at 42). Nothing in the record contradicts Dr. Hopkins on these points. For these reasons, the health exception does not save the D & E Mandate at this stage of the proceeding.

4. Women Effected

To sustain a facial challenge and grant a preliminary injunction, this Court must find that the challenged D & E Mandate is an undue burden for a large fraction of women for whom the provision is an actual, rather than an irrelevant, restriction. The Court makes that finding here and rejects defendants' argument that the D & E Mandate is not unconstitutional because it "affects only a small fraction of abortions" (Dkt. No. 23, at 29). Dr. Hopkins maintains that the D & E Mandate impacts all D & Es in Arkansas (Dkt. No. 4, ¶¶ 14, 16). Under the D & E Mandate, the only D & E that would be legal is one in which a physician successfully induces fetal demise through an additional procedure prior to starting the evacuation phase of D & E (Dkt. No. 3, at 7). Dr. Hopkins claims that, because it is not feasible or safe to induce fetal demise through an additional procedure in every patient prior to starting the evacuation phase of D & E, providers would not start any D & E because they may not be able to complete the procedure without violating the D & E Mandate (Dkt. No. 3, at 7).

Little Rock Family Planning Services, along with Dr. Hopkins, provides care to women from throughout Arkansas and from other states (Dkt. No. 6, ¶ 5). Dr. Hopkins is aware of no physicians, other than those with whom he practices at Little Rock Family Planning Services, who provide second trimester abortion care (Dkt. No. 32–2, ¶ 2). In other words, there are no other providers in Arkansas that could fill this gap in care.

The Court makes the following findings of fact with respect to the fraction of women effected by the D & E Mandate. Little Rock Family Planning Services is the only abortion care provider for women seeking abortion after 10.0 weeks LMP in Arkansas (Dkt. No. 5, ¶ 6; Dkt. No.

6, ¶ 2). Each year, Little Rock Family Planning provides approximately 3,000 abortions, of which approximately 20% occur during the second trimester (Dkt. No. 6, ¶ 16). Standard D & E accounts for 100% of second trimester abortions reported in Arkansas in 2015 (Dkt. No. 5, ¶ 17). Standard D & E accounts for 95% of all second trimester abortions nationally (Dkt. No. 4, ¶¶ 14–16; Dkt. No. 5, ¶ 17). The vast majority of standard D & Es currently occur from 14.0 to 18.0 weeks LMP (Dkt. No. 5, ¶¶ 25–26). Of the 638 D & Es reported in Arkansas in 2015, 407 or 64% took place during these earliest weeks of the second trimester (Dkt. No. 6, ¶ 17).

*31 This Court determines that, if the Court considers the D & E Mandate relevant for Arkansas women who select standard D & E during the early weeks of the second trimester, it creates an undue burden for a large fraction of these women. In Arkansas in 2015, 407 women had a standard D & E from 14.0 to 18.0 weeks LMP. The D & E Mandate would unduly burden 100% of these women because, if the D & E Mandate goes into effect, standard D & E abortions will no longer be performed in Arkansas due to ethical and legal concerns regarding compliance with the law, thereby rendering abortions essentially unavailable in the State of Arkansas starting at 14.0 weeks LMP.

This Court determines that, even if the Court considers the D & E Mandate relevant for Arkansas women who select standard D & E throughout the second trimester, it creates an undue burden for a large fraction of these women. In Arkansas in 2015, 638 women selected standard D & E. If the D & E Mandate goes into effect, standard D & E abortions will no longer be performed in Arkansas due to ethical and legal concerns regarding compliance with the law, thereby rendering abortions essentially unavailable in the State of Arkansas starting at 14.0 weeks LMP. In that case, 100% or all 638 of these women will experience a substantial obstacle to abortion.[9]

The Court determines that it is not appropriate to use as the denominator all Arkansas women who obtained second trimester abortion; the D & E Mandate is only relevant for Arkansas women who elected to have the standard D & E. Regardless, even if the Court considers the D & E Mandate relevant for Arkansas women who select abortion throughout the second trimester, these numbers do not change. In 2015, no Arkansas woman elected to have an induction abortion; all Arkansas women elected to have a standard D & E. 638 women selected standard D & E. If the D & E Mandate goes into effect, standard D & E abortions will no longer be performed in Arkansas due to ethical and legal concerns regarding compliance with the law, thereby rendering abortions essentially unavailable in the State of Arkansas starting at 14.0 weeks LMP. In that case, 100% or all 638 of these women will experience a substantial obstacle to abortion.

Many patients of Little Rock Family Planning Services are low-income. Approximately 30 to 40% of patients obtain financial assistance to pay for their abortion care (Dkt. No. 6, ¶ 5). Many patients of Little Rock Family Planning Services struggle in their lives and in their efforts to access the medical care they need (Dkt. No. 6, ¶ 5). The time and effort it takes to make the necessary plans to access medical care cause anxiety and stress and cause financial pressure for women seeking care at Little Rock Family Planning Services (Dkt. No. 6, ¶ 8). If Little Rock Family Planning Services no longer performed abortions in Arkansas after 14.0 weeks LMP, financial and logistical issues would burden 30 to 40 % of these women, or 191 to 255, in finding any alternate care out of state. These findings, coupled with the finding that abortions would essentially be unavailable in the State of Arkansas starting at 14.0 weeks LMP if the D & E Mandate takes effect, bolster this Court's conclusion that if the D & E Mandate takes effect a large fraction of Arkansas women who select abortion throughout the second trimester would experience a substantial obstacle to abortion.

*32 To the extent defendants maintain induction abortion would be an available abortion option in Arkansas if the D & E Mandate were to take effect, the only record evidence before the Court is that there were no induction abortions reported in Arkansas in 2015 (Dkt. No. 5, ¶ 12). Further, an induction abortion requires a hospital or hospital-like facility; it is not performed in a second-trimester outpatient clinic. If hospitals in Arkansas are providing any abortion care, it is in only rare circumstances (Dkt. No. 5, ¶ 6). Induction abortion can take over 24 hours, and for some patients, this procedure may span multiple days. This procedure entails labor, which can involve pain requiring significant medication or anesthesia, and which may be psychologically challenging for some women (Dkt. No. 4, ¶ 14; Dkt. No. 5, ¶ 12). Because induction involves an in-patient stay, requiring up to three days of

hospitalization, as opposed to an out-patient procedure, there is an enormous cost difference between induction and the out-patient standard D & E procedure (Dkt. No. 4, ¶ 14). In some women, an induction abortion fails, and the woman needs intervention in the form of D & E for her safety. This is infrequent, but this does occur (Dkt. No. 4, ¶ 15; Dkt. No. 5, ¶ 12). In approximately 5% to 10% of induction abortions, the woman must undergo an additional surgical procedure to remove a retained placenta. Induction abortion also can cause uterine rupture, which is rare but can be life threatening and can be of particular concern for women who have had multiple previous cesarean deliveries (Dkt. No. 4, ¶ 15; Dkt. No. 25–4, ¶ 8). Controlling precedent does not require the Court to consider this method, but even if it did, for these reasons, the Court rejects induction abortion as a viable alternative second trimester option in Arkansas.

2. Irreparable Harm

[34] Enforcement of the D & E Mandate will inflict irreparable harm on Dr. Hopkins and the fraction of women for whom the Mandate is relevant as there is no adequate remedy at law. It is well-settled that the inability to exercise a constitutional right constitutes irreparable harm. *See Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury.") (citations omitted); *accord Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (quoting *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L.Ed.2d 547 (1976)).

In the absence of an injunction, the fraction of women for whom the Mandate is relevant would immediately lose the right to obtain a pre-viability abortion anywhere in the State of Arkansas after 14.0 weeks LMP. Therefore, the second requirement for an order preliminarily enjoining enforcement of the D & E Mandate is satisfied.

3. Balancing Of Harms

[35] In the absence of an injunction, the fraction of women for whom the Mandate is relevant would immediately lose the right to obtain a pre-viability abortion anywhere in the State of Arkansas after 14.0 weeks LMP if the D & E Mandate were allowed to take effect. Whereas, if an injunction issues, a likely unconstitutional law passed by Arkansas legislators will not go into effect. The threatened harm to Dr. Hopkins and the fraction of women for whom the Mandate is relevant clearly outweighs whatever damage or harm a proposed injunction may cause the State of Arkansas.

4. Public Interest

[36] It is in the public interest to preserve the *status quo* and to give the Court an opportunity to evaluate fully the lawfulness of the D & E Mandate without subjecting Dr. Hopkins, or his patients, or the public to any of the law's potential harms.

The Court notes that the Eleventh Amendment bars relief against an allegedly unconstitutional provision if the named state officials do not have the authority to enforce it. U.S. Const. amend XI; *see also Hutchinson*, 803 F.3d at 957–58. Therefore, the preliminary injunction does not extend to the private civil-enforcement provisions under the D & E Mandate.

It is therefore ordered that Dr. Hopkins's motion for preliminary injunction is granted to the extent that defendants are preliminarily enjoined from enforcing the provisions of Ark. Code Ann. § 20–16–1803 and Ark. Code Ann. § 20–16–1805 which imposes criminal penalties on a person who violates Ark. Code Ann. § 20–16–1803(a).

B. Medical Records Mandate
(Counts III and IV based H.B. 1434)

Dr. Hopkins seeks a preliminary injunction based on count three, which alleges that the Medical Records Mandate violates the Due Process Clause of the United States Constitution by placing an undue burden on Dr. Hopkins's patients' right to liberty and privacy, and count four, which alleges that the Medical Records Mandate violates the Due Process Clause due to its vagueness.

*33 The Medical Records Mandate subjects physicians to civil liability and criminal penalties for violating the law. It requires:

(b) Before performing an abortion, the physician or other person who is performing the abortion shall:

(1) (A) Ask the pregnant woman if she knows the sex of the unborn child.

(B) If the pregnant woman knows the sex of the unborn child, the physician or other person who is performing the abortion shall inform the pregnant woman of the prohibition of abortion as a method of sex selection for children; and

(2) (A) Request the medical records of the pregnant woman relating directly to the entire pregnancy history of the woman.

(B) An abortion shall not be performed until reasonable time and effort is spent to obtain the medical records of the pregnant woman as described in subdivision (b)(2)(A) of this section.

(c) If this section is held invalid as applied to the period of pregnancy prior to viability, then the section shall remain applicable to the period of pregnancy subsequent to viability.

Ark. Code Ann. § 20–16–1804.

A physician who "knowingly performs or attempts to perform an abortion" prohibited by this law "is guilty of a Class A misdemeanor" under Arkansas law. Ark. Code Ann. § 20–16–1805. This includes punishment of up to one year in jail, a fine, or both. Ark. Code Ann. §§ 5–4–201, 5–4–401. A physician who violates the law also is subject to civil penalties and professional sanctions, including but not limited to suspension or revocation of his or her medical license for "unprofessional conduct" by the Arkansas State Medical Board. Ark. Code Ann. § 20–16–1806.

[37] [38] [39] [40] Dr. Hopkins does not challenge the requirement that a physician not perform an abortion knowing that the woman is seeking the abortion solely on the basis of the sex of the embryo or fetus. Ark. Code Ann. § 201–6–1804(a), (b)(1). Dr. Hopkins is unaware of such a case in Arkansas (Dkt. No. 5, ¶ 30; Dkt. No. 6, ¶ 22). Defendants do not dispute that this type of challenge solely to the Medical Records Mandate is permissible. [10]

1. Likelihood Of Success On The Merits: Due Process Clause

a. Applicable Law

*34 [41] To determine whether Dr. Hopkins is likely to succeed on his challenge to the Medical Records Mandate under the Due Process Clause, this Court applies the undue burden standard. In ***Whole Woman's Health***, the Supreme Court clarified that this undue burden analysis "requires that courts considers the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S.Ct. at 2309. The Supreme Court has determined that, to prevail, a plaintiff bringing a facial challenge must demonstrate that "in a large fraction of cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791. To sustain a facial challenge and grant a preliminary injunction, this Court must make a finding that the Medical Records Mandate is an undue burden for a large fraction of women for whom the law is relevant.

The law that controls the Court's evaluation of Dr. Hopkins's challenge to the Medical Records Mandate under the Due Process Clause is set forth in more detail at Section IV.A.1.a. of this Order.

b. Analysis Of The Medical Records Mandate

1. State's Interest

The Arkansas legislature included "legislative findings and purpose" when enacting this law. Ark. Code Ann. § 20–16–1802. The purpose of the law is to "[b]an abortions performed solely for reasons of sex-selection" and to "[p]rotect women from the risks inherent in late-term abortions." Ark. Code Ann. § 20–16–1802(b). Dr. Hopkins does not seek a preliminary injunction on or challenge enforcement of the law with respect to the ban on abortions performed solely for reasons of sex-selection. Dr. Hopkins does seek a preliminary injunction challenging enforcement of the Medical Records Mandate.

With respect to maternal health, the Arkansas legislature made the following findings:

> (A) It is undisputed that abortion risks to maternal health increase as gestation increases.
>
> (B) The risk of death for pregnant women at eight (8) weeks' gestation is one (1) death per one million (1,000,000) and rises to:
>
> (i) One (1) death per twenty-nine thousand (29,000) abortions between sixteen (16) and twenty (20) weeks' gestation, and
>
> (ii) One (1) death per eleven thousand (11,000) abortions at twenty-one (21) weeks' gestation or later;
>
> (C) A woman is thirty-five (35) times more likely to die from an abortion performed at twenty (20) weeks' gestation than she would have been had the abortions been performed in the first trimester;
>
> (D) A woman is ninety-one (91) times more likely to die from an abortion performed at twenty-one (21) weeks' gestation or later than she would have been had the abortion been performed in the first trimester; and
>
> (E) Because abortions performed solely based on the sex of a child are generally performed later in pregnancy, women undergoing these abortions are unnecessarily exposed to increased health risks, including an exponentially higher risk of death.

Ark. Code Ann. § 20–16–1802(a)(2).

2. Burdens Imposed On Women

[42] **[43]** **[44]** **[45]** Defendants maintain that the Medical Records Mandate applies only in "situations where the woman knows the sex" of the embryo or fetus (Dkt. No. 23, at 48–49). When examining the meaning of a criminal statute, the Supreme Court of Arkansas applies these principles:

> We construe criminal statutes strictly, resolving any doubts in favor of the defendant. *Hagar v. State*, 341 Ark. 633, 19 S.W.3d 16 (2000). We also adhere to the basic rule of statutory construction, which is to give effect to the intent of the legislature. *Id.* We construe the statute just as it reads, giving the words their ordinary and usually accepted meaning in common language, and if the language of the statute is plain and unambiguous, and conveys a clear and definite meaning, there is no occasion to resort to rules of statutory interpretation. *Id.* Additionally, in construing any statute, we place it beside other statutes relevant to the subject matter in question and ascribe meaning and effect to be derived from the whole. *Id.*

***35** *Short v. State*, 349 Ark. 492, 79 S.W.3d 313, 315 (2002).

The Supreme Court of Arkansas also explained:

> It is a well-settled principle of statutory construction that statutes (will) receive a common-sense construction, and, where one word has been erroneously used for another, or a work omitted, and the context affords the means of correct, the proper word will be deemed substituted or supplied. This is but making the strict letter of the statute yield to the obvious intent of the Legislature.

Henderson v. Russell, 267 Ark. 140, 589 S.W.2d 565, 568 (1979) (citations omitted).

The Supreme Court of Arkansas stated:

> Statutes will not be defeated on account of mistakes, errors or omissions, provided the intent of the General Assembly can be collected from the whole statute. *Hazelrigg v. Board of Penitentiary Commissioners*, 184 Ark. 154, 40 S.W.2d 998 (1931). We have often held that the title of an act is not controlling in its construction

> even though it is a matter to be considered in determining the meaning of a statute which is otherwise ambiguous. *Matthews v. Byrd*, 187 Ark. 458, 60 S.W.2d 909 (1933). Likewise, the language used in the title of an act is not controlling but may play a part in explaining ambiguities in the body of the statute. *City of Conway v. Summers*, 176 Ark. 796, 4 S.W.2d 19 (1928). We examine the title of an act only for the purpose of shedding light on the intent of the General Assembly. *Lyerley v. Manila School District No. 15*, 214 Ark. 245, 215 S.W.2d 733 (1948).

Henderson, 589 S.W.2d at 568.

In *Henderson*, acknowledging that controlling law, the Supreme Court of Arkansas reviewed language to determine if an emergency had been defined by the Arkansas legislature such that the emergency clause was effective, accelerating the effective date of the law. The court examined the following:

> Where County Officers must have Deputies and employees necessary to carry out the essential activities of County Government, it is hereby found that it is in the best interest of County Government that no person be employed as a Deputy or County Employee who is related by affinity or consanguinity within the third degree to any elected official. Therefore, an emergency is hereby declared to exist and this Ordinance being necessary for the immediate preservation of public peace, health and safety shall be in full force and effect from and after its passage and approval.

Henderson, 589 S.W.2d at 569. The Supreme Court of Arkansas reasoned "[t]here [wa]s simply nothing in the emergency clause to indicate a real emergency existed" and declared "that the emergency clause had failed and the ordinance [would] take effect as it would have had there been no emergency clause." *Id.*

Applying those principles here, the Court concludes that Ark. Code Ann. § 20–16–804(b) should be read as enacted; there is no ambiguity in the language. The portion which is the Medical Records Mandate in subsection (2) is a second, independent requirement from the requirement in subsection (1) of asking the pregnant woman if she knows the "sex of the unborn child." In other words, as written, the statute requires that "[b]efore performing an abortion, the physician or other person who is performing the abortion shall" comply with both subsection (1) *and* (2) of § 804(b). In fact, "and" appears at the end of subsection (1)(b) preceding subsection (2). There is no language in the statute as written that limits subsection (2) to instances in which the pregnant woman knows the "sex of the unborn child" or makes subsection (2) dependent upon the woman's answer to subsection (1) of § 804(b).

***36** Defendants do not argue a mistake, error, or omission in § 804(b). Instead, defendants argue that the Medical Records Mandate says something that it plainly does not (Dkt. No. 23, at 48). If the Court is permitted under Arkansas law and these circumstances to look to the title and legislative findings, the Court finds more persuasive defendants' argument that the legislature intended something other than what the statute plainly says (Dkt. No. 23, at 49). However, the Court is not convinced that it may look to the title and legislative findings here.

Regardless, at this stage of the proceeding, the Court will consider both interpretations of the Medical Records Mandate. The Court finds as a matter of law that the Medical Records Mandate impermissibly delays or bars most abortions for which the law is relevant, contains no health exception, and imposes prohibitive requirements on providers.

Based on the record evidence before the Court, obtaining medical records is medically indicated for only a fraction of abortion patients (Dkt. No. 4, ¶ 9; Dkt. No. 5, ¶¶ 33–34; Dkt. No. 6, ¶ 24). The doctors at Little Rock Family Planning Services request medical records for approximately 25 patients per year out of the approximately 3,000 women patients each year (Dkt. No. 6, ¶¶ 24, 32). The patients for whom doctors at Little Rock Family Planning Services request medical records include

patients who have received a diagnosis of fetal anomaly, decided to end the pregnancy, and received a referral to Little Rock Family Planning Services and patients for whom the doctor believes the records could be useful because of a woman's medical condition (Dkt. No. 6, ¶ 24).

Even then, a request for only certain records related to a specific medical issue is appropriate (Dkt. No. 4, ¶ 9; Dkt. No. 5, ¶¶ 33–34; Dkt. No. 6, ¶ 24). For Little Rock Family Planning Services to obtain a patient's medical records, the patient must first sign a form authorizing Little Rock Family Planning Services to obtain the medical records. That authorization is then sent along with a request to the health care provider. Little Rock Family Planning Services staff then follow-up with a phone call to the health care provider, if necessary (Dkt. No. 6, ¶ 25).

Because Little Rock Family Planning Services typically requests records related to some aspect of the care the patient will receive, and therefore involve a specific request, not a request for the patient's full medical history, there is no fee charged for the records (Dkt. No. 6, ¶ 25). Even with these specific requests, it takes time to obtain a patient's medical records from another health care provider and may take a few hours or up to several weeks (Dkt. No. 6, ¶ 26).

When certain records related to a specific medical issue are requested, unless the records are transmitted and received very quickly, any medical benefit of waiting for the records is outweighed by the fact that delaying abortion care increases the risks associated with the procedure for the patient (Dkt. No. 4, ¶ 9; Dkt. No. 5, ¶ 39).

Attempting to comply with the Medical Records Mandate would mean waiting until Dr. Hopkins had spent an undefined amount of time trying to obtain records. Even for very targeted requests, it may take anywhere from a few hours to several weeks to receive records (Dkt. No. 6, ¶ 26). The types of requests required by the Medical Records Mandate likely will mean delays in receiving records would be even greater (*Id.*). Federal law allows United States providers 30 days for the initial response to records requests; the actual medical records may follow later; and the patients' recourse for non-production of records involves review by government officials and/or litigation. 45 C.F.R. § 164.524. Delay would be compounded for patients receiving pregnancy related care outside of Arkansas or outside of the United States, and for patients whose records are in another language and must be translated into English (Dkt. No. 5, ¶ 14; Dkt. No. 6, ¶ 30).

*37 The delay caused by the Medical Records Mandate is not quantified by the law, as explained in this Court's discussion regarding the vagueness of this provision. Due to this delay, enforcement of the Medical Records Mandate could cause a woman's time to obtain abortion care in Arkansas to expire. Currently, Arkansas bans abortions after 21.6 weeks LMP. Ark. Code Ann. § 20–16–1405 (2013) (banning abortion after 20.0 weeks post-fertilization, which is 22.0 weeks LMP). This seems especially likely given defendants' contention that the Medical Records Mandate "applies only to potential sex-selection abortions—which by definition are later-term abortions where the mother knows the sex of the child she is carrying." (Dkt. No. 23, at 49). If what defendants contend is true, for those women, time is of the essence in accessing abortion care in Arkansas. Even defendants concede that delay increases the risk to the woman, given the findings of fact of the legislature that "sex-selection abortions are generally performed later in pregnancy and that the risks from abortion to maternal health increase as gestation increases" (Dkt. No. 23, at 49). *See* Ark. Code Ann. § 20–16–1802(a)(2) (legislative findings).

The record evidence is that delay can push a woman past the point in pregnancy at which she can receive a medication abortion, requiring a woman who prefers that method to have a procedure with instrumentation that she would otherwise not have. Delay can push a woman from a first-trimester to a second-trimester procedure, or from a one-day to a two-day procedure in the second trimester. Delay can also push a woman past the point at which she can obtain an abortion at Little Rock Family Planning Services and in Arkansas (Dkt. No. 6, ¶ 13).

The record evidence is that the risks associated with legal abortion utilizing current methods increase as pregnancy progresses, particularly if that delay pushes a woman from the first trimester to the second trimester. Studies demonstrate increased risks of complications, such as bleeding and uterine perforation, associated with abortions performed later in pregnancy (Dkt. No. 4, ¶ 10). The record evidence is that delay also means that a woman may pay more for the abortion procedure itself because the procedure becomes more complex as pregnancy advances (Dkt. No. 6, ¶ 14).

This type of delay, and the impact of this delay, erects a substantial obstacle to abortion access. *See Schimel*, 806 F.3d at 920 (explaining that delay causes women to "forgo first-trimester abortions and instead get second-trimester ones, which are more expensive and present greater health risks. Other women would be unable to obtain any abortion, because the delay would push them past" the point in pregnancy at which abortion care is available), *cert. denied*, —— U.S. ——, 136 S.Ct. 2545, 195 L.Ed.2d 869 (2016). When examining the judicial bypass procedures, which allow minors to obtain abortion care without otherwise mandated parental involvement, the Supreme Court made clear such procedures are unconstitutional unless they assure an expeditious time frame for completion of the process. *See, e.g., Bellotti*, 443 U.S. at 644, 99 S.Ct. 3035 (holding that judicial bypass process for minors "must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained"); *Causeway Medical Suite v. Ieyoub*, 109 F.3d 1096, 1110 (5th Cir. 1997) (striking down judicial bypass statute that lacked time limits and noting that "[s]uch open-ended bypass procedure has never been approved"), *overruled on other grounds by Okpalobi v. Foster*, 244 F.3d 405 (5th Cir. 2001).

The Medical Records Mandate's requirements apply even where abortion is necessary to prevent a serious health risk to the woman; the Medical Records Mandate has no exception to allow physicians to act without the required medical records search in cases where a serious health risk to the woman is present. Although the plain text of the Medical Records Mandate does not permit a physician to proceed based on health risks to the woman, the State of Arkansas argues such an exception is implicit in the law. The State of Arkansas points to language in the law that prohibits an abortion "solely on the basis of the sex of the unborn child" and argues that, if an abortion is needed for health reasons, the abortion is not a sex-selection abortion prohibited by the law (Dkt. No. 22, at 35). The Court rejects this argument. As an initial matter, defendants point to section (a) for this language, not section (b) that includes the Medical Records Mandate. *See* Ark. Code Ann. § 20–16–1804. There is no language in section (b) from which the Court could infer this exception. Instead, the language of section (b) requires medical records requests for women's "entire pregnancy history" and the delay of "reasonable time and effort to obtain the medical records" before any abortion can be performed. Ark. Code Ann. § 20–16–1804(b). Further, other Arkansas statutes regarding abortion, including some challenged here, specifically include specific health exception language. That language is absent in this statute. This Court has no legal basis from which to read that language, or such an exception, into the Medical Records Mandate.

***38** In addition, there is record evidence that compliance with the Medical Records Mandate would drain providers' resources: the staff, copying, and processing costs of requesting records and attempting to compile all the records for the great majority of patients would be overwhelming (Dkt. No. 6, ¶¶ 24, 32). Little Rock Family Planning Services provides medical care to approximately 3,000 women each year, the majority of whom have had one or more prior pregnancies, during which the women received medical care from one or more providers or received care for a current pregnancy (Dkt. No. 6, ¶ 32). Each woman would have to gather past information, including identifying her past providers and the dates she received service, to complete a signed request for each former provider (Dkt. No. 6, ¶ 33). Little Rock Family Planning Services, which provides approximately 3,000 abortions of the 3,800 abortions reported in Arkansas each year cannot process that volume of requests (Dkt. No. 6, ¶¶ 24, 31). As a result, implementation of the Medical Records Mandate will simply shut down care for those patients (Dkt. No. 3, at 34).

The Arkansas Medical Board advises that Arkansas medical providers can charge per-page copying fees and separate fees for retrieval of records from storage. See Ark. Code Ann. 16–46–106 (2008). The record evidence is that, when making a request for a patient's complete medical record, a fee usually is charged for obtaining the records (Dkt. No. 6, ¶ 33).

At this stage of the proceeding, the Court acknowledges the evidence in the record that compliance would violate the women's confidentiality: requesting medical records would disclose the fact of the woman's pregnancy and her abortion decision to all her previous and current pregnancy related health care providers (Dkt. No. 5, ¶ 38; Dkt. No. 6, ¶ 28).[11] Little Rock Family Planning Services is a well-known abortion provider. Any request for medical records made by Little Rock Family Planning

Services, in and of itself, discloses that the patient likely is seeking an abortion. As a result, Little Rock Family Planning Services does not request records with a woman's prior written consent, and some women specifically request that Little Rock Family Planning Services not seek records from another health care provider because the woman does not want that provider to know of the pregnancy and abortion decision (Dkt. No. 6, ¶ 27). The record evidence is that some women have informed Little Rock Family Planning Services that the women fear hostility or harassment from their other health care providers for deciding to seek an abortion (Dkt. No. 6, ¶ 28).

Many women do not want that to occur (Dkt. No. 5, ¶ 38; Dkt. No. 6, ¶ 28). As a result, this Court concludes that there is record evidence that this violation of confidentiality would further interfere with a woman's right to decide to end a pregnancy. *Bellotti*, 443 U.S. at 655, 99 S.Ct. 3035. It will cause women to forgo abortion in Arkansas rather than risk disclosure to medical providers who they know oppose abortion or who are family friends or neighbors (Dkt. No. 6, ¶ 28).

3. Balancing

The burdens imposed by the Medical Records Mandate appear to serve no proper state purpose. *See Whole Woman's Health*, 136 S.Ct. at 2318 (an abortion regulation is unconstitutional where it provides "few, if any" medical benefits); *Schimel*, 806 F.3d at 920 (emphasizing that the "feebler the medical grounds (in this case nonexistent), the likelier" it is that any burden on abortion is disproportionate and therefore undue). The ban on abortions sought based solely on sex, with its enforcement through Ark. Code Ann. 20–16–1804(a), stands on its own. Dr. Hopkins does not challenge this ban.[12] Any aid the Medical Records Mandate might provide for this ban has not been established by record evidence nor has it been shown by record evidence to outweigh the substantial burdens that the Medical Records Mandate imposes on abortion access for the women for whom the Mandate is relevant. "This necessarily means that the burden to be considered undue is greatly reduced as a requirement as the benefit from the regulation becomes miniscule, if any." *W. Ala. Women's Ctr.*, 217 F.Supp.3d at 1321–22.

*39 Here, the Medical Records Mandate requires blanket requests for entire medical histories related to pregnancy care. There is record evidence that such blanket requests will increase the delay in receiving records and the cost of obtaining records (Dkt. No. 6, ¶¶ 24, 32, 33). These delays may put abortion care out of reach for many of the women for whom this law is relevant, especially given defendants' contention that the Medical Records Mandate "applies only to potential sex-selection abortions—which by definition are later-term abortions where the mother knows the sex of the child she is carrying." (Dkt. No. 23, at 49; *see also* Dkt. No. 6, ¶ 13). Time is of the essence in accessing abortion care in Arkansas, given the limits under Arkansas law on when abortions may be performed. All parties conceded that any delay in receiving abortion care increases the risk to the woman. *See* Ark. Code Ann. § 20–16–1802(a)(2) (legislative findings).

Although defendants state "a patient is always more likely to receive better care when her physician has greater knowledge of her health history," there is no evidentiary support for this statement in the record before the Court. It is an unsupported statement by defense counsel. In fact, the record evidence before this Court is that the current standard abortion care does not require a physician to obtain medical records for entire medical histories related to pregnancy care for women before providing abortion care (Dkt. No. 5, ¶¶ 31–42; Dkt. No. 6, ¶¶ 24–34). *See Whole Woman's Health*, 136 S.Ct. at 2315 (determining, when conducting the undue burden analysis, that "[t]here [was] considerable evidence in the record supporting the District Court's findings indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary").

From the record evidence before the Court, obtaining medical records is medically indicated for only a fraction of abortion patients (Dkt. No. 4, ¶ 9; Dkt. No. 5, ¶¶ 33–34; Dkt. No, 6, ¶ 24). Even then, a request for only certain records related to a specific medical issue is appropriate (Dkt. No. 4, ¶ 9; Dkt. No. 5, ¶¶ 33–34; Dkt. No. 6, ¶ 24). When certain records related to a specific medical issue are requested, unless the records are transmitted and received very quickly, any medical benefit of waiting for the records is outweighed by the fact that delaying abortion care increases the risks associated with the procedure for the patient (Dkt. No. 4, ¶ 9; Dkt. No. 5, ¶ 39).

Nothing in the Medical Records Mandate explains what a doctor is to do with these records. Defendants in their filings assert that "[m]edical records pertaining to a woman's past pregnancy history is likely to shed light on whether a woman is seeking a sex-selection abortion. For example, medical records documenting that a woman who had previously been pregnant with two girls and two boys who had abortions of the two girls would be highly probative of whether or not a woman who was currently pregnant with a girl was seeking a sex-selection abortion." (Dkt. No. 22, at 34–35). This factual assertion that medical records "likely" will provide this information is not supported by any record evidence. Moreover, the Medical Records Mandate does not address this; nothing in the Mandate directs a doctor to use these records to aid in making a determination whether a woman seeks an abortion based solely on gender. That link is not established by the language of the Medical Records Mandate, nor is it established by any evidence in the record.

Defendants further state "[t]he discovery that a woman was seeking a sex-selection abortion may indicate that the woman has a need for counseling or is herself the victim of a coercive domestic partner who demands that she abort any child of a particular sex." (Dkt. No. 23, at 50). Again, there is no support for this in the record. It is another unsupported statement by defense counsel.

*40 There also is no evidence in the record from defendants to inform this Court on the ease with which a provider like Dr. Hopkins could comply with the Medical Records Mandate, as defendants suggest is possible. Instead, the only evidence in the record is that provided by Dr. Hopkins, which is based on experience and personal knowledge, and that evidence establishes the substantial burdens of compliance. *See Whole Woman's Health*, 136 S.Ct. at 2318 (examining, when conducting the undue burden analysis, "the costs that a currently licensed abortion facility would have to incur to meet" the challenged regulation). The Court accepts Dr. Hopkins's evidence on this point at this stage of the proceeding.

There also is no evidence in the record to counter the Court's conclusion that compliance would implicate the women's confidentiality.

These harms are not dependent on unusual, as-applied circumstances, despite defendants' contention to the contrary (Dkt. No. 23, at 51). There is no record evidence to support that assertion. That assertion is directly contradicted by the record.

For all of these reasons, this Court concludes at this stage of the proceedings that Dr. Hopkins is likely to succeed in showing that the Medical Records Mandate imposes an undue burden on a large fraction of women for whom the law is relevant. The record includes sufficient evidence from which Dr. Hopkins satisfies his burden to present evidence of causation that the Mandate's requirements will lead to this effect. *See Whole Woman's Health*, 136 S.Ct. at 2313. Therefore, at this stage of the proceeding, the Court determines the Medical Records Mandate is likely unconstitutional.

4. Women Effected

To sustain a facial challenge and grant a preliminary injunction, this Court must find that the challenged Mandate is an undue burden for a large fraction of women for whom the provision is an actual rather than an irrelevant restriction. Regardless of how the Medical Records Mandate is construed—whether it effects all 3,000 women in Arkansas seeking an abortion, as Dr. Hopkins contends, or only those women who know gender when seeking an abortion, as defendants contend, it creates an undue burden for a large fraction of them. The Medical Records Mandate does very little to advance defendants' interest, for the reasons explained. Compliance with the Medical Records Mandate for these women presents substantial obstacles to abortion care by increasing delays, very possibly putting abortion care out of reach for women late in pregnancy, increasing health risks to women as gestational age advances, increasing costs associated with compliance, and implicating privacy concerns. The vagueness of this Mandate, especially in relation to whom it applies and how long the provider is expected to wait for records, prohibits the Court from deducing fractions of women burdened by the Mandate with any specificity.

If the Medical Records Mandate is intended to apply to all women seeking an abortion in Arkansas, based on record evidence from 2015 which is the last year for which the Arkansas Department of Health published statistics, it will apply to 3,771 women—all of the women who sought an abortion in Arkansas during that year

(Dkt. No. 3, at 3 n.1). If the Medical Records Mandate requires providers to seek records for all women before providing abortion, the Mandate will substantially burden all women's access. If the Medical Records Mandate requires providers to seek records only for women who have had prior pregnancies, approximately two-thirds of the women who obtained abortions in 2015 had had one or more previous live births; this equates to approximately 2,514 women (Dkt. No. 5, ¶ 32). There is record evidence that, of the remaining third, "many" will have had care earlier in their current pregnancy, a previous stillbirth, miscarriage, or abortion, or a previous ectopic or molar pregnancy (Dkt. No. 5, ¶ 32). The remaining third represents 1,256 women; the Court construes "many" as "a large number of" which is how the term is commonly defined. *Many*, The Oxford Dictionary (10th ed. 2014). All of these figures represent large fractions of the women effected.

***41** If the Medical Records Mandate is intended to apply only to women who know the sex of the unborn child, those are the women for whom the law is relevant, and the undue burdens created by the Medical Records Mandate will apply to all of those women. The burdens of the Mandate will substantially outweigh its benefits, based on the record before this Court for the reasons explained. The Court takes judicial notice that one typical method to determine the sex of an unborn child is through ultrasound and that other, essentially commercial, services are offered to aid women in determining the sex of an unborn child. *See* F.R.E. 201(b)(2); *see also* Pam Belluck, *Test Can Tell Fetal Sex at 7 Weeks, Study Says*, N.Y.TIMES, Aug. 11, 2011, at 1, *available at* http://www.nytimes.com/2011/08/10/health/10birth.html (citing Stephanie A. Devaney, Glenn E. Palomaki, Joan A. Scott, and Diana W. Bianchi, Noninvasive Fetal Sex Determination Using Cell–Free Fetal DNA: A Systematic Review and Meta Analysis, 306(6) JAMA 627–636 (2011)).

Arkansas law expressly requires "[a] person authorized to perform abortions under Arkansas law" to perform an abdominal ultrasound for the stated purpose of testing for a heartbeat, and, if a fetal heartbeat is detected during the abdominal ultrasound examination, the physician must inform the pregnant woman in writing that the fetus possesses a heartbeat and the statistical probability of bringing the unborn child to term based on gestational age. Ark. Code Ann. § 20–16–1303(a), (b), (c), (d)(1), (d)(2), (e); *see Edwards*, 8 F.Supp.3d 1091 (examining Ark. Code Ann. §§ 20–16–1301 through 1307, declaring portions of the heartbeat testing and portions of the disclosure requirements constitutional and declaring the ban on abortions when fetal heartbeat is detected and the fetus has reached twelve weeks' gestation unconstitutional). These informational disclosures are required regardless of whether the fetus has attained twelve weeks' gestation. *Edwards*, 8 F.Supp.3d 1091. Although a physician would by necessity determine the gestational age of the fetus as part of determining the statistical probability of bringing the fetus to term, the Act does not mandate a particular method for determining gestational age. *Id.* There was evidence of record in *Edwards*, upon which the court relied, that "[e]arly in pregnancy, abdominal ultrasound does not produce images that are sufficiently clear to permit accurate gestational dating. As a result, some other method of gestational dating, such as vaginal ultrasound, must be used." *Edwards*, 8 F.Supp.3d at 1096 (citing the sworn declaration of Janet Cathey, M.D., board-certified in the speciality of obstetrics and gynecology).[13] These requirements make it much more likely that a woman in Arkansas will know the sex of the unborn child before her abortion.

2. Likelihood Of Success On The Merits: Vagueness

[46] [47] [48] [49] Dr. Hopkins contends that the Medical Records Mandate is void for vagueness. Under the Due Process Clause, "an enactment is void for vagueness if its prohibitions are not clearly defined." *D.C. v. City of St. Louis*, 795 F.2d 652, 653 (8th Cir. 1986) (quoting *Grayned v. City of Rockford*, 408 U.S. 104, 108–09, 92 S.Ct. 2294, 33 L.Ed.2d 222 (1972)). Due process requires that laws provide fair notice by giving a "person of ordinary intelligence a reasonable opportunity to know what is prohibited, so he may act accordingly." *Id.* Due process also demands explicit standards to prevent arbitrary or discriminatory actions by those charged with enforcement. *Id.*

***42 [50] [51] [52] [53]** "As generally stated, the void-for-vagueness doctrine requires that a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement." *Gonzales*, 550

U.S. at 167, 127 S.Ct. 1610 (quoting *Kolender v. Lawson*, 461 U.S. 352, 357, 103 S.Ct. 1855, 75 L.Ed.2d 903 (1983); *Posters 'N' Things, Ltd. v. United States*, 511 U.S. 513, 525, 114 S.Ct. 1747, 128 L.Ed.2d 539 (1994)). "The degree of vagueness that the Constitution tolerates... depends in part on the nature of the enactment," with greater tolerance for statutes imposing civil penalties and those tempered by scienter requirements. *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 498–99, 102 S.Ct. 1186, 71 L.Ed.2d 362 (1982). The Court notes that it must abide by "the elementary rule that every reasonable construction must be resorted to, in order to save a statute from unconstitutionality." *Gonzales*, 550 U.S. at 153, 127 S.Ct. 1610. In construing the law narrowly to avoid constitutional doubts, the Court "must also avoid a construction that would seriously impair the effectiveness of [the law] in coping with the problem it was designed to alleviate." *See United States v. Harriss*, 347 U.S. 612, 623, 74 S.Ct. 808, 98 L.Ed. 989 (1954).

Dr. Hopkins contends that, if a law "threatens to inhibit the exercise of constitutionally protected rights," the Constitution requires an especially high level of clarity. *Village of Hoffman Estates*, 455 U.S. at 499, 102 S.Ct. 1186. He further argues that when violation of a law carries criminal penalties, "a strict test of specificity" applies. *D.C.*, 795 F.2d at 654. Even if a law "nominally imposes only civil penalties," if those are "prohibitory and stigmatizing," courts still undertake a close review for vagueness. *Village of Hoffman Estates*, 455 U.S. at 499, 102 S.Ct. 1186. Dr. Hopkins argues that the challenged provisions "triggers the strictest vagueness review, because it both inhibits the exercise of constitutionally protected rights to liberty and privacy...and imposes criminal and other stigmatizing penalties, such as the finding of 'unprofessional conduct' and revocation of a physician's license to practice. H.B. 1434 § 1." (Dkt. No. 3, at 32).

In regard to the Medical Records Mandate, Dr. Hopkins maintains that the statute "fails to define what constitutes 'reasonable time and effort'; fails to define or in any way limit the scope of 'medical records relating directly to the entire pregnancy history' of the patient; and fails to specify what actions, if any, the physician is to take upon receiving any records." (Dkt. 3, at 12). Further, Dr. Hopkins asserts that the statute does not include a provision allowing the physician to proceed based on medical risks to the woman, regardless of how serious.

Dr. Hopkins asserts that the Medical Records Mandate is unconstitutionally vague in at least three respects. Dr. Hopkins states that, first, it gives no guidance as to what constitutes "reasonable time and effort," leaving the word "reasonable" with no content and no context (*Id.*). Dr. Hopkins poses potential questions to illustrate the alleged vagueness of the provision: "How much effort is needed to be 'reasonable'? How long is it 'reasonable' to wait for records?" (*Id.*). The Court recognizes the possibility that a medical records requests may take days, weeks, or even months to fulfill, if the request is responded to at all.

Dr. Hopkins notes that the Medical Records Mandate also does not explain whether any facts—beyond the effort expended to request records and the number of days or weeks of delay spent awaiting their arrival—are relevant in assessing what is "reasonable." Dr. Hopkins posits more questions to illustrate this alleged ambiguity: "Is the amount of money the physician or patient must pay for searching, copying, and, where necessary, securing translation of records into English relevant to what is 'reasonable'?" (Dkt. No. 3, at 32). In response, at the hearing on the instant motion, defendants argued that, "Indeed, common sense tells us that physicians and their staffs are perfectly capable of determining, based on their years of experience, whether they have made reasonable efforts." Defendants further assert that "But [Dr. Hopkins's] claim that the reasonableness standard is vague is insufficient as a matter of law to plead a vagueness claim. Numerous criminal and civil statutes use an objective 'reasonableness' standard to evaluate conduct. To hold that Act 733's medical-records provision is void for vagueness due to its incorporation of an objective reasonableness standard would entail finding that *all* such prohibitions violate the Constitution." (Dkt. No. 23, at 52–53).

***43** Defendants cite a number of cases that they claim support their argument that "Courts have rejected allegations of vagueness where abortion laws use an objective reasonableness standard. *See Ohio v. Akron Ctr. for Reprod. Health*, 497 U.S. 502, 519, 110 S.Ct. 2972, 111 L.Ed.2d 405 (1990) (rejecting a facial challenge to a statute that requires physicians to give notice by telephone or in person if this can be done through 'reasonable efforts'); *Twin-Lick Oil Co. v. Marbury*, 91 U.S. 587, 23 L.Ed. 328 (1875) (what counts as 'reasonable time' must be arrived at by a consideration of all elements which

affect the question at hand); *United States v. Bewig*, 354 F.3d 731, 738 (8th Cir. 2003) (rejecting the argument that a statute that criminally prohibited activity that included 'having reasonable cause to believe' a matter was unconstitutionally vague); *Karlin v. Foust*, 188 F.3d 446, 497 (7th Cir. 1999) (rejecting the arguments that a statute incorporating an objective reasonableness standard is unconstitutionally vague and imposes an undue burden on a woman's right to choose an abortion)." (Dkt. No. 23, at 53). The Court has reviewed the cases and finds them unpersuasive, as they involve facts distinctly different from the facts in this matter. Most of the cases cited involve similar words in different types of laws and do not involve vagueness claims at all. *See Johnson*, 135 S.Ct. 2551 (striking down as unconstitutionally vague a provision about "serious potential risk of physical injury to another"); *Twin–Lick Oil Co*, 91 U.S. 587, 23 L.Ed. 328 (rejecting effort to rescind a contract).

The Court has reviewed many cases in which language like this has resulted in a determination of unconstitutional vagueness. *See, e.g., Johnson v. United States*, —— U.S. ——, 135 S.Ct. 2551, 192 L.Ed.2d 569 (2015) (determining that the Armed Career Criminal Act violates due process); *Kolender*, 461 U.S. 352, 103 S.Ct. 1855 (enjoining as vague a statute that required providing "credible and reliable" identification when requested by police officer); *Smith v. Goguen*, 415 U.S. 566, 94 S.Ct. 1242, 39 L.Ed.2d 605 (1974) (enjoining as vague a statute that failed to define "contemptuous treatment" of the flag, whether intentional or inadvertent); *Reproductive Health Services of Planned Parenthood of the St. Louis Region, Inc. v. Nixon*, 428 F.3d 1139 (8th Cir. 2005) (enjoining the enforcement of the state's informed-consent statute that required physicians to advise of "risk factors" of abortion and imposed punishments for "knowing" violations); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386 (8th Cir. 1999) (striking as unconstitutionally vague the state's "partial birth abortion" ban which included definitions of the prohibited acts).

Dr. Hopkins also notes that there is no exception in the provision allowing a physician to provide care absent "reasonable time and effort" where necessary to protect a patient from increased risk, yet increased risk will, according to Dr. Hopkins, necessarily result from the indefinite delay inherent in the Mandate. Dr. Hopkins poses another set of questions illustrating potential ambiguities: "Is it 'reasonable' to proceed without receiving records in order to avoid the increased risk of a one-month delay? A one-week delay? To avoid pushing a woman's care into the second trimester, past 14.0 weeks LMP, when she would need a D & E, which entails higher risks than a suction abortion? If so, does that mean it is 'reasonable' to delay for a number of weeks-and make follow up contacts to numerous providers seeking records-for a patient who initially seeks care at 10 weeks, but not for a patient who initially seeks care at 13 weeks and some number of days? For that patient, how many days is it 'reasonable' to delay? Is just making the initial records request alone ever 'reasonable'? Is it 'reasonable' to force a woman to delay three weeks if she has the financial resources and flexibility to return in 3 weeks, but not reasonable in the case of a woman struggling financially, who absolutely cannot return-and pay for a later, more expensive procedure-in three weeks?" (Dkt. No. 3, at 33).

The Court shares Dr. Hopkins's concerns regarding these inquiries and concludes that the phrase "reasonable time and effort" is subjective in nature and has no specified boundaries. Thus, the Court finds that the Medical Records Mandate fails to provide fair notice and could potentially result in arbitrary enforcement. *See, e.g., Grayned*, 408 U.S. at 113, 92 S.Ct. 2294 (highlighting the due process problems with a "completely subjective standard").

***44** Dr. Hopkins next argues that the Medical Records Mandate fails to define or in any way limit the scope of "medical records relating directly to the [patient's] entire pregnancy history." In response, defendants argue that, "[i]t is difficult to imagine what could be unclear about this requirement. The Act requires that a physician request (1) any medical records that (2) directly relate to (3) the woman's (4) past pregnancies, with a view toward determining whether a woman is seeking a sex-selection abortion." (Dkt. No. 23, at 54). Defendants cite *Gonzales* for the proposition that "[t[he Act provides doctors of ordinary intelligence a reasonable opportunity to know what is [required]." *Gonzales*, 550 U.S. at 149, 127 S.Ct. 1610 (citation omitted) (internal quotation marks omitted).

As written, the term "reasonable" search seems to apply to a potential myriad of past and present physicians who treated the woman, and both current and any prior pregnancies or medical visits related to a current or prior

pregnancy. (Dkt. No. 5, ¶ 23). The term "direct" in the provision is also unclear. To illustrate, Dr. Hopkins poses inquiries: "Does a 'direct' relation to a patient's entire pregnancy history include care by her general practitioner for pregnancy-related symptoms? Must [Dr. Hopkins] request records from a laboratory or ultrasound center?" (Dkt. No. 3, 33–34).

Lastly, as related to the Medical Records Mandate, Dr. Hopkins argues that the mandate "gives no direction whatsoever on what actions, if any, the physician is to take upon receiving any records." (Dkt. No. 3, at 34). Dr. Hopkins questions whether "with a mandatory search for the patient's 'entire pregnancy history,' must the physician review every record, and, if so, for what purpose?" (*Id.*). Dr. Hopkins asserts that "[c]ontrary to the Due Process Clause, the Medical Records Mandate fails to provide clear standards for physicians, inviting arbitrary enforcement by prosecutors, the Arkansas Medical Board, and others. Dr. Hopkins is therefore likely to prevail in this challenge to the Mandate." (*Id.*). In response, defendants contend that "[b]ut the Act clearly specifies what actions a physician must *not* take—namely, the doctor must not intentionally perform an abortion with knowledge that the woman is seeking it on the basis of the child's sex. Again, the medical records are likely to shed light on this matter. In the context of this Act, it is clear what the doctor is supposed to look for in the records —indications that the woman is seeking a sex-selection abortion." (Dkt. No. 23, at 49). However, the assertion that the provision specifies what actions a doctor must not take is inapposite in relation to the contention that the terms indicating what actions a doctor must take are vague.

Dr. Hopkins contends that "defendants' own arguments highlight the Medical Records Mandate's vagueness." (Dkt. No. 32, at 49). Dr. Hopkins notes that defendants appear to understand the reference in § 20–16–1804(b)(2)(A) to a woman's "entire pregnancy history" to apply only to "past pregnancies," yet no language in the statute specifies that limitation. Instead, the language is "entire pregnancy history," and that language as used in (b)(2)(A) could be read to include only the current "pregnancy history" or, to give more meaning to "entire," to encompass both past pregnancies *and* the women's current "pregnancy history." Dr. Hopkins argues that "defendants arbitrarily assume that the reference only applies to past pregnancies, however, and pick one of three possible readings of this unclear statutory language." (Dkt. No. 53, at 75–76).

Dr. Hopkins asserts that defendants provide no clarity as to the universe of medical records that might "directly relate to" a woman's "entire pregnancy history," and instead leave "unclear and undefined the universe of prior health care providers from whom records *must* be requested to remove § 20–16–1804(b)(2)(A)'s prohibition on proceeding with an abortion." (Dkt. No. 32, at 53).

***45** Dr. Hopkins notes that as to § 20–16–1804(b)(2)(B)'s requirement of "reasonable time and effort" to obtain the medical records after (2)(A)'s requests, defendants try to import a notion of "objective reasonableness" that is nowhere referenced in the law and offer no concrete description of what "reasonable time and effort" in this context might be. Instead, defendants refer to cases concerning different standards in other contexts or to professionals' medical judgments. *Id.* Their arguments wholly fail to clarify what Arkansas means by "reasonable time and effort" in the context of § 20–16–1804(b)(2)'s non-medically indicated, blanket searches for entire medical histories, or what physicians are to do with records if and when they arrive.

Defendants rely heavily on *Gonzales* to argue that the Medical Records Mandate is not unconstitutionally vague. Defendants state that "[i]n *Gonzales*, the Court upheld the partial-birth abortion ban in the face of a facial vagueness challenge similar to that which Hopkins makes here." (Dkt. No. 23, at 51–52). The Court, however, is not persuaded by this comparison, as it finds *Gonzales* factually distinct from the instant case. In *Gonzales*, the Court stated that "[i]ndeed, [the statute at issue in that case] sets forth 'relatively clear guidelines as to prohibited conduct' and provides 'objective criteria' to evaluate whether a doctor has performed a prohibited procedure. *Posters 'N' Things, supra*, at 525–526, 114 S.Ct. 1747." *See Gonzales*, 550 U.S. at 149, 127 S.Ct. 1610. The Court finds that the Mandates challenged on vagueness grounds in this case contain no objective criteria or clear guidelines.

Defendants argue that "the statute clearly states precisely what conduct is criminally prohibited: knowingly performing or attempting to perform an abortion with the intent to terminate a pregnancy before spending reasonable time and effort to obtain medical records directly relating to the previous pregnancies of a woman

who knows the sex of the child she is carrying." (Dkt. No. 23, at 52). Defendants miss the mark with this contention. The vagueness of the Medical Records Mandate lies not in its description of what conduct is prohibited; it lies in its terminology used to outline compliance with the mandate. For all of these reasons, based on the record before the Court at this stage of the proceeding, Dr. Hopkins is likely to succeed on his claim that the Medical Records Mandate is unconstitutionally vague.

3. Irreparable Harm

[54] Enforcement of the Medical Records Mandate will inflict irreparable harm on Dr. Hopkins and the fraction of women for whom the Mandate is relevant as there is no adequate remedy at law. It is well-settled that the inability to exercise a constitutional right constitutes irreparable harm. *See Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury.") (citations omitted); *accord Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (quoting *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L.Ed.2d 547 (1976)).

In the absence of an injunction, a large fraction of women in Arkansas for whom the Medical Records Mandate is relevant– whether that is all 3,000 women in Arkansas seeking an abortion if the Medical Records Mandate is construed as Dr. Hopkins contends, or those women who know gender when seeking an abortion, if the Medical Records Mandate is construed as defendants contend —face an undue burden resulting from the Mandate's obstacles to abortion access. Dr. Hopkins faces the violation of his due process rights due to the enforcement of a vague statute. Therefore, the second requirement for an order preliminarily enjoining enforcement of the Medical Records Mandate is satisfied.

4. Balancing Of Harms

*46 **[55]** In the absence of an injunction, a large fraction of women in Arkansas for whom the Medical Records Mandate is relevant– whether that is all 3,000 women in Arkansas seeking an abortion if the Medical Records Mandate is construed as Dr. Hopkins contends, or those women who know gender when seeking an abortion, if the Medical Records Mandate is construed as defendants contend—face an undue burden resulting from the Mandate's obstacles to abortion access. Dr. Hopkins faces violation of his due process rights due to the enforcement of a vague statue. Whereas, if an injunction issues, a likely unconstitutional law passed by Arkansas legislators will not go into effect. The threatened harm to Dr. Hopkins and the fraction of women for whom the Mandate is relevant clearly outweighs whatever damage or harm a proposed injunction may cause the defendants.

5. Public Interest

[56] It is in the public interest to preserve the *status quo* and to give the Court an opportunity to evaluate fully the lawfulness of the Medical Records Mandate without subjecting Dr. Hopkins, or his patients, or the public to any of the law's potential harms.

The Court notes that the Eleventh Amendment bars relief against an allegedly unconstitutional provision if the named state officials do not have the authority to enforce it. U.S. Const. amend XI; *see also Hutchinson*, 803 F.3d at 957–58. Therefore, the preliminary injunction does not extend to the private civil-enforcement provisions under the Medical Records Mandate. *See* Ark. Code Ann. § 20–16–1806.

It is therefore ordered that Dr. Hopkins's motion for preliminary injunction is granted to the extent that defendants are preliminarily enjoined from enforcing the provisions of Ark. Code Ann. § 20–16–1804(b)(2)(A) and (b)(2)(B); § 20–16–1805 which imposes criminal penalties on a physician or other person who violates § 20–16–1804(b)(2)(A) and (b)(2)(B); and § 20–16–1806 to the extent it permits a physician to have his or her medical license suspended or revoked for violating § 20–16–1804(b)(2)(A) and (b)(2)(B).

C. Local Disclosure Mandate (Counts VI and VIII based on H.B. 2024)

Dr. Hopkins seeks a preliminary injunction based on his as-applied challenge to the Local Disclosure Mandate in count six, which alleges that the local disclosure mandate violates the Due Process Clause of the United

States Constitution by placing an undue burden on Dr. Hopkins's patients' right to liberty and privacy, and count eight, which alleges that the local disclosure mandate violates the Due Process Clause by violating Dr. Hopkins's patients' right to informational privacy.

The Arkansas legislature amended an existing law that required a physician who performed an abortion on a child less than fourteen (14) years of age at the time of the abortion to preserve fetal tissue extracted during the abortion in accordance with rules adopted by the office of the Arkansas State Crime Laboratory. Ark. Code Ann. § 12–18–108(a)(1). The amendment raised the age from fourteen (14) to seventeen (17), requiring physicians who perform abortions on women less than seventeen (17) years of age at the time of the abortion to preserve fetal tissue extracted during the abortion in accordance with rules adopted by the office of the Arkansas State Crime Laboratory. Ark. Code Ann. § 12–18–108(a)(1). A physician's failure to comply with the law "shall constitute unprofessional conduct under the Arkansas Medical Practices Act," Ark. Code Ann. § 12–18–103(c), and subject the physician to license suspension or revocation and other disciplinary penalties, Ark. Code Ann. § 17–95–409 (2009).

The Arkansas State Crime Laboratory has prescribed rules to implement the law, including a requirement that "[a]ll products of conception should be preserved" and immediately frozen, in an air-tight container, with a label that includes "the patient's name and date of birth." Ark. Admin. Code § 171.00.2(1)–(2) (2013). The "physician must properly establish and maintain the chain of custody for this evidence," by completing a "Fetal Tissue Submission Form," and contacting the local law enforcement where the child resides. The form includes the name and "address of the victim, [and her] parent and/or legal guardian," her date of birth, and the name and date of birth of the "suspect." Ark. Admin. Code § 171.00.2(3).

*47 The rule for "proper disposal of fetal tissue preserved" under this law requires that "[u]pon completion of DNA analysis, any remaining samples will be disposed of by the Arkansas State Crime Laboratory after receipt of a 'letter of destruction' from the respective investigating agency." Ark. Admin. Code § 171.00.2(4). The law does not apply to treatment for spontaneous miscarriage or removal of an ectopic pregnancy—only abortion. Ark. Code Ann. § 12–18–103(2)(B).

Dr. Hopkins brings an as-applied challenge. He does not seek a preliminary injunction regarding enforcement of the preexisting law, which already required him to transmit to local law enforcement identifying information of children less than 14 years old, along with the fetal tissue extracted during the abortion (Dkt. No. 1, ¶¶ 91–92). Instead, he maintains the as-applied challenge on behalf of patients under the age of seventeen (17) at the time of the abortion for whom there is no basis to report to the state Hotline under the Child Maltreatment Act (Dkt. No. 1, ¶ 92).

1. Likelihood Of Success On The Merits: Due Process

a. Applicable Law

[57] To determine whether Dr. Hopkins is likely to succeed on his challenge to the Local Disclosure Mandate under the Due Process Clause, this Court applies the undue burden standard. "A statute, which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." ***Whole Woman's Health***, 136 S.Ct. at 2309 (quoting *Casey*, 505 U.S. at 877, 112 S.Ct. 2791 (plurality opinion)). Abortion regulations that "have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Id.* (quoting *Casey*, 505 U.S. at 878, 112 S.Ct. 2791 (plurality opinion)). Because this is an as-applied challenge, the Court confines its examination of the application of the Local Disclosure Mandate to that particular context. *Voinovich*, 130 F.3d at 193–94.

b. Analysis Of The Local Disclosure Mandate

1. State's Interest

No legislative findings accompany the Local Disclosure Mandate. The Court does not have an explanation from the legislature of the purpose of the law. The State of Arkansas argues that the law advances the interests of protecting children from sexual abuse and in prosecuting those who sexually exploit them (Dkt. No. 23, at 49). The Court assumes the legitimacy of these interests. ***Whole***

Woman's Health, 136 S.Ct. at 2310 (assuming that the State had legitimate state interests where the statute did not contain any legislative findings).

2. Burdens Imposed On Women

As originally enacted, the law applied only to women who are 13 years of age or younger at the time of the abortion. [14] The amended law regarding maintaining forensic samples now requires that, for every woman who is less than 17 years of age at the time of the abortion, her physician must (1) disclose the fact of her abortion to her local police department and (2) preserve all embryonic or fetal tissue from her abortion as "evidence." Ark. Code Ann. 12–18–108(a)(1). Dr. Hopkins challenges the new requirements only as applied to those women ages 14, 15, and 16 whose sexual activity indicates no potential sexual abuse and, therefore, is not covered by the reporting requirements under the Arkansas Child Maltreatment Act (the "Non–CMA Teenage Patients"). *See generally* Ark. Code Ann. §§ 12–18–401 *et seq.*

***48** In Arkansas, almost all patients in this affected 14 to 16 year old age group are receiving abortion care with a parent involved. Some may have husbands involved, as well. According to Dr. Hopkins, the sexual activity of 14 to 16 year old women does not constitute reportable "sexual abuse" under Arkansas law when it takes place with a similar-age partner or that teenager's spouse, and not with a caretaker or involving forcible compulsion. *See, e.g.*, Ark. Code Ann. §§ 12–18–103(20)(B) –103(20)(C). Such similar-age consensual sexual activity does not constitute criminal activity. Ark. Code Ann. §§ 5–14–101(2009), 103 (2013), 110 (2016), 124 (2013), 125 (2013), 126 (2009) 127 (2009). For 16–year-old women, because Arkansas does not regulate the age of their consensual sexual partners, abuse reporting or criminality arises when the person involved uses force or is a caretaker or other person in a similar relationship of power. Ark. Code Ann. §§ 5–14–101(2009), 103 (2013), 110 (2016), 124 (2013), 125 (2013), 126 (2009), 127 (2009).

The sexual partner of the Non–CMA Teenage Patients would be a consensual partner, typically of the same age or similar age, and based on common sense and these cited provisions of Arkansas law would not be a criminal or abuse suspect, just as the patient would not be a victim. The Local Disclosure Mandate requires the physician to disclose the Non–CMA Teenage Patient's abortion to her local law enforcement and mandates retention of tissue from her abortion indefinitely in a crime laboratory, even when facts indicate no potential abuse or criminality. Regarding the proper disposal of the fetal tissue, the Local Disclosure Mandate assumes that the context is always criminal or an abuse investigation. That is not the case for all Non–CMA Teenage Patients. There is nothing in the law to address disposal of tissue when there is no need for any investigation.

Dr. Hopkins argues that the law can be read to bar medication abortion for patients under 17 years of age through its mandate that "[a]ll products of conception" be preserved (Dkt. No. 3, at 18). With medication abortion, a physician cannot collect and preserve "[a]ll products of conception" and thus would risk violating this law and its implementing Rules if performing a medication abortion. *See* Ark. Admin. Code § 171.00.2(1) (2014). Consistent with applicable standards of care and when appropriate, Dr. Hopkins offers 14 to 16 year old women medication abortion (Dkt. No. 5, ¶ 52). After counseling, and in nearly all cases with the assistance of an involved parent or guardian, many women decide that medication abortion is a better choice for them (Dkt. No. 5, ¶ 52; Dkt. No. 6, ¶ 36). In certain instances, these women prefer or will better tolerate medication abortion, for example if the woman has never had a pelvic exam, or when uterine anomalies or high body mass index are present (Dkt. No. 5, ¶ 52).

For all Non–CMA Teenage Patients, physicians would have to disclose and explain during their pre-abortion counseling the Local Disclosure Mandate's requirement of local law enforcement reporting and tissue transmittal (Dkt. No. 5, ¶ 50; Dkt. No. 6, ¶ 46). These Non–CMA Teenage Patients' sexual activity does not implicate child abuse concerns or criminal law. This discussion of law enforcement contact and "evidence" collection would be punitive, confusing, and likely humiliating for these women and their families. To prevent notice to local law enforcement, some Non–CMA Teenage Patients may forgo abortion care or at least significantly delay their care by seeking a procedure out of state (Dkt. No. 5, ¶ 50; Dkt. No. 6, ¶ 46).

The required notice of abortion and transmittal of "crime lab" evidence will stigmatize these women and potentially subject them to a range of negative reactions that can

occur in response to the revealed decision to end a pregnancy. There is record evidence of the stigmatizing treatment these women may receive (Dkt. No. 6, ¶¶ 27–28). Absent any indication of child maltreatment, providing information to local law enforcement is itself a harm (Dkt. No. 3, at 20). *See generally Lambert v. Wicklund*, 520 U.S. 292, 295, 117 S.Ct. 1169, 137 L.Ed.2d 464 (1997) (if an abortion statute requires parental consent, a judicial bypass that "ensure[s] the minor's anonymity" is required to satisfy constitutional requirements); *Casey*, 505 U.S. at 894, 112 S.Ct. 2791 (recognizing an undue burden of spousal notification requirement on married women who seek an abortion without such disclosure; a "significant number of women... are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion"); *Thornburgh v. Am. Coll. of Ob. & Gyn.*, 476 U.S. 747, 766–67, 106 S.Ct. 2169, 90 L.Ed.2d 779 (1986) (emphasizing that a "woman and her physician will necessarily be more reluctant to choose an abortion if there exists a possibility that her decision and her identity will become known" to third parties), *overruled in part on other grounds, Casey*, 505 U.S. at 881, 112 S.Ct. 2791. While officers will presumably treat such information as confidential, once the information is known by local community members and written on required documents, there are risks to these young women's privacy, which can engender fear on the part of these young women (Dkt. No. 5, ¶ 47; Dkt. No. 6, ¶ 45).

*49 The required disclosure to local law enforcement of this information creates heightened concerns for those few teenagers who rely on the judicial bypass so that they need not involve a parent in their abortion decision; the young women who, along with one parent or guardian, decide not to inform another parent or household member because of concerns; and other young women living under circumstances that might expose them to physical or other serious harm should the fact of their abortion or sexual activity become known in their home or local community (Dkt. No. 3, at 20).

3. Balancing

The State of Arkansas maintains that the Local Disclosure Mandate applies only to surgical abortions where a physician extracts fetal tissue, not to medication abortion (Dkt. No. 22, at 49). Defendants maintain that a woman will not be obstructed from obtaining an abortion by these regulations. Defendants contend that the Local Disclosure Mandate "rationally promotes the health and safety of young women who have had an abortion and does not require disclosures that are either broad or public" and therefore "does not create an undue burden on the decision of whether or not to have an abortion." (Dkt. No. 23, at 67). The Court disagrees.

This Court concludes that, as a matter of law, the Local Disclosure Mandate serves no valid state purpose as applied to Non–CMA Teenage Patients, those 14 to 16 year old women who become pregnant through consensual sexual intercourse with, for example, a teenager of the same age. The Non–CMA Teenage Patients' health care is purely a private matter. There is no mandatory reporting required, and there is no role for local law enforcement or the Arkansas State Crime Laboratory under those circumstances. The State of Arkansas argues that the law advances the interests of protecting children from sexual abuse and in prosecuting those who sexually exploit them (Dkt. No. 23, at 49). There exists no state interest in addressing child abuse and criminal conduct in these situations. Under *Casey* and ***Whole Woman's Health***, there is no "constitutionally acceptable" interest to balance against the substantial obstacles erected by the Local Disclosure Mandate for Non–CMA Teenage Patients. Therefore, the Local Disclosure Mandate imposes an undue burden on Non–CMA Teenage Patients' right to access abortion. ***Whole Woman's Health***, 136 S.Ct. at 2309–10.

The Court finds this regardless of whether the Local Disclosure Mandate prohibits medication abortion for all 14, 15, and 16 year old patients, as Dr. Hopkins contends, or not. Dr. Hopkins maintains that, by requiring the abortion provider to preserve all embryonic or fetal tissue from her abortion as "evidence," the Local Disclosure Mandate eliminates the possibility of medication abortion because collection of embryonic or fetal tissue by the abortion provider is not feasible with medication abortion. *See* Ark. Code Ann. 12–18–108(a)(1). If this is the case, it is a factor in the Court's analysis of the burden imposed by the Local Disclosure Mandate for this as-applied challenge. There are other factors the Court considers, as well. In Arkansas, approximately 83% of all abortions occur during the first trimester of pregnancy (*Id.*). Of those abortions occurring in the first trimester of pregnancy, 581 or approximately 20% were medication

abortions, and 2,552 were suction abortions in 2015 (Dkt. No. 5, at 36).

When the General Assembly first enacted Ark. Code Ann. § 12–18–108, it applied exclusively to abortions involving girls age 13 and under and targeted "sexual crimes on child victims" and "sexually predatory adults." H.B. 1447 1(a), (b) (Findings and Purposes), 89th Gen. Assemb., Reg. Sess. (Ark. 2013). It was directed at "reporting medical facilit[ies]" and explicitly contemplated that its application was co-extensive with mandatory reporting. *Id.*, (1)(b)(3), (5). That focus on girls 13 and under also tracked the criminal threshold for statutory rape. Ark. Code Ann. § 5–14–103(a)(3)(A) (2013).

***50** The Local Disclosure Mandate greatly expands the reach of this section, without justification, to non-criminal, non-reportable activity that is affirmatively constitutionally protected: abortions sought by Non–CMA Teenage Patients after sexual activity under circumstances indicating no form of sexual abuse.

Defendants maintain that "there is no basis outside of [Dr.] Hopkins's subjective judgment for defining a 'discrete and well-defined' class of children to whom [this portion of the law] may be unconstitutionally applied." (Dkt. No. 23, at 65). When arguing this, defendants assert that "an abortion provider is not in the best position to identify many victims of sexual abuse. Local law enforcement are in a much better position to make a judgment concerning whether children are victims of sexual abuse." (*Id.*). There is no evidentiary support in the record for these assertions. These assertions are contradicted by Dr. Hopkins's role, and all doctors' roles, as mandatory reporters under existing Arkansas law.

The Arkansas Child Maltreatment Act includes detailed definitions of sexual abuse and sexual exploitation. This Act already enlists mandatory reporters such as Dr. Hopkins and the staff of Little Rock Family Planning Services to report to the specialized state Child Abuse Hotline whenever there is an indication that a child may be the victim of maltreatment. The class of children to whom the Local Disclosure Mandate may be unconstitutionally applied is defined by the Child Maltreatment Act itself, under current Arkansas law, not Dr. Hopkins's "subjective judgment," as defendants contend.

Defendants point out that "law enforcement officers operate under codes of confidentiality that prevent improper public disclosures of sensitive information." (Dkt. No. 23, at 66–67). In pertinent part, defendants assert that the Law Enforcement Code of Ethics requires, "Whatever I see or hear of a confidential nature or that is confided to me in my official capacity will be kept ever secret unless revelation is necessary in the performance of my duty." (Dkt. No. 23, at 67). Defendants also assert that records kept by the Arkansas State Crime Laboratory are privileged and confidential under Ark. Code Ann. § 12–12–312 and that such records can "be released only under the direction of a court of competent jurisdiction, the prosecuting attorney having criminal jurisdiction over the case, or the public defender appointed or assigned to the case." Ark. Code Ann. 12–12–312(a)(1)(A)(ii).

However, Arkansas state law already determined the central repository for any suspicions of child maltreatment —the state Child Abuse Hotline, which is run by a specially trained unit of the State Police, along with the Department of Human Services. In fact, local law enforcement are themselves mandatory reporters to the state Child Abuse Hotline. If local law enforcement have information sufficient to raise suspicions of illegal sexual activity, then local law enforcement officers must raise their suspicions with the state Child Abuse Hotline, which then coordinates any investigation and response. Ark. Code Ann. 12–18–402(a)(1)(A), (b)(13). There is record evidence that supports this system of reporting to the Child Abuse Hotline is a better method, given how it is staffed and that those staffers are better trained than local law enforcement to address abuse allegations (Dkt. No. 6, ¶¶ 41, 43, 45). *See also* ***Whole Woman's Health***, 136 S.Ct. at 2311 (examining the undue burden of the challenged regulation and determining that "nothing in Texas' record evidence" showed that "compared to prior law (which required a 'working arrangement' with a doctor with admitting privileges), the new law advanced Texas' legitimate interest in protecting women's health."). There is no record evidence to the contrary.

***51** Dr. Hopkins maintains that the Local Disclosure Mandate is irrelevant to ensuring that law enforcement in Arkansas will continue to have the full cooperation of Dr. Hopkins and his colleagues at the clinic in collecting tissue evidence in situations like these, where there are

facts indicating rape, of a patient of any age, or other sexual abuse (Dkt. No. 5, ¶ 43; Dkt. No. 6, ¶¶ 35, 39).

For Non–CMA Teenage Patients, there are no facts indicating abuse. There is no required reporting under Arkansas's Child Abuse Hotline, and thus, for Non–CMA Teenage Patients, the Local Disclosure Mandate "separately intervenes to require disclosure to local police in the teenager's hometown, of those purely private facts of an abortion and earlier sexual activity." (Dkt. No. 32, at 55).

Defendants point out that the statute requires that, "[b]efore submitting the tissue under subdivision (a)(1) of this section, the physician shall redact protected health information as required under the [federal] Health Insurance Portablity and Accountability Act of 1996," but that reference to redaction may be misleading (Dkt. No. 23, at 66). Ark. Code Ann. § 12–18–108(a)(2). The Local Disclosure Mandate, and its implementing Rules, specifically require that personal information accompany the "evidence" collected, and HIPPA allows such disclosures made to law enforcement pursuant to state law. Here, the Local Disclosure Mandate and its implementing Rules require disclosure of the woman's abortion to local law enforcement in her home jurisdiction, infinite storage of tissue labeled with her name on it, and use of a Fetal Tissue Transmission Form, which includes not only her name, but her parent's name, her home address, and the name of the "suspect," her sexual partner. HIPAA does not appear to permit redaction here.

"[R]ecordkeeping and reporting provisions that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible." *Casey*, 505 U.S. at 900, 112 S.Ct. 2791. The local disclosure of a teenager's identity, her address, her parents, her sexual partner, and the tissue from her abortion as contemplated by the Local Disclosure Mandate does not equate to, and is much more invasive than, the anonymous reporting and record-keeping about abortion upheld in *Casey*, 505 U.S. at 900, 112 S.Ct. 2791, and in various states to serve public health purposes, including Arkansas.

As defendants note, the Local Disclosure Mandate applies to minors who receive an abortion who already have either parental consent or a judicial bypass. Ark. Code Ann. §§ 20–16–804 and 20–16–809. Defendants claim that "[i]t is unlikely that a child who—having obtained parental consent or judicial bypass—will be deterred from obtaining an abortion merely because the law requires her name to be transmitted to local law enforcement and the fetal remains preserved after the fact." (Dkt. No. 23, at 66). There is no factual support in the record for this assertion.

Instead, there is factual support in the record that "many" patients of Little Rock Family Planning Services "are desperate not to disclose the reasons for travel and appointments to seek abortion care." (Dkt. No. 6, ¶ 8). Further, there is record evidence that some women specifically request that Little Rock Family Planning Services not seek medical records from another healthcare provider because the women do not want that provider to know of the pregnancy and abortion decision (Dkt. No. 6, ¶ 27). Some women fear hostility or harassment from the other healthcare providers for deciding to seek an abortion (Dkt. No. 6, ¶ 28). There is evidence that, even documents meant to be confidential, such as medical record requests, can be disclosed and result in efforts to dissuade women from obtaining abortions (Dkt. No. 6, ¶ 28).

***52** The substantial obstacles erected are access to abortion if the mandate prohibits medication abortion and preventing or delaying abortion care for these Non–CMA Teenage Patients by confusing them with discussions of evidence, suspects, and investigations as those terms are used in the Local Disclosure Mandate when those terms do not apply to them; humiliating them by disclosing very private facts about their sexual activity and reproductive choices in writing to local community members; and making them fearful of the reaction by local law enforcement in their home jurisdiction if they proceed with the care they seek and their abortion is therefore disclosed. These burdens apply to all Non–CMA Teenage Patients.

Even if these obstacles were not substantial, the Local Disclosure Mandate would still fail constitutional review in this as-applied challenge because it lacks any justifying state purpose as applied to Non–CMA Teenage Patients. ***Whole Woman's Health***, 136 S.Ct. at 2309–10; *Van Hollen*, 738 F.3d at 788 (stressing that the weaker the state's grounds for its regulations, "the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate

or gratuitous"). That tips the balance when compared to the burdens, and the Court is required to balance. When examining the burden imposed by the abortion regulation challenged in ***Whole Woman's Health***, the Court observed that it is true that increased driving distance to access an abortion does not "always" constitute an "undue burden," as noted in *Casey*, but the ***Whole Woman's Health*** Court said the "the virtual absence of any health benefit" from the challenged hospital affiliation requirement was a factor to be weighed in making an undue burden ruling. 136 S.Ct. at 2313. Balancing is therefore required. *Id.*, at 2309. *See also Comprehensive Health of Planned Parenthood Great Plains v. Williams*, No. 2:16-cv-04313, 2017 WL 1407656, *3 (W.D. Mo. April 19, 2017) (the necessary balancing "means the burden to be considered undue is greatly reduced... as the benefit from the regulation becomes miniscule, if any").

Further, Dr. Hopkins maintains that, in terms of noticing possible abuse and revealing sexual activity, there is no difference between teenagers seeking abortion care and those seeking care for miscarriage, sexually transmitted infections, contraception or prenatal care, but only abortion patients are targeted by the Local Disclosure Mandate, including Non–CMA Teenage Patients for whom there is no indication at all of actual abuse. *See* ***Whole Woman's Health***, 136 S.Ct. at 2315 (discussing under-inclusive scope of the provision).

Because this is an as-applied challenge, the Court confines its examination of the application of the Local Disclosure Mandate to Non–CMA Teenage Patients and determines that, in that particular context, the Local Disclosure Mandate imposes an undue burden on abortion access. *Voinovich*, 130 F.3d at 193–94. The record includes sufficient evidence from which Dr. Hopkins satisfies his burden to present evidence of causation that the Mandate's requirements will lead to this effect. *See* ***Whole Woman's Health***, 136 S.Ct. at 2313.

2. Likelihood Of Success On The Merits: Informational Privacy

[58] Dr. Hopkins also contends that the Local Disclosure Mandate violates both decisional and informational privacy (Dkt. No. 3, at 38). Dr. Hopkins further states that "H.B. 2024 serves no valid state purpose as applied to fourteen to sixteen year-olds, who have become pregnant through consensual sexual intercourse with a partner of the same age" (Dkt. No. 3, at 40). Dr. Hopkins states that, in situations of that nature, a teenager's health care is a purely private matter with no mandatory reporting and no need to involve the local law enforcement or the Arkansas State Crime Laboratory.

***53** Dr. Hopkins further argues that his patients have a strong, constitutionally-protected interest in avoiding disclosure of their sexual activity and their abortion to local law enforcement (Dkt. No. 3, at 43). He points to the constitutional safeguards provided to individuals from unwarranted governmental intrusions into their personal lives. *See Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996) (citing *Whalen v. Roe*, 429 U.S. 589, 598 n.23, 97 S.Ct. 869, 51 L.Ed.2d 64 (1977)). This right protects against undue burdens on private decisions, but also shields the confidentiality of "highly personal matters" in "the most intimate aspects of human affairs." *Id.* (quoting *Wade v. Goodwin*, 843 F.2d 1150, 1153 (8th Cir. 1988)). The Eighth Circuit has described this constitutional right as applying to information where disclosure would be "a shocking degradation or an egregious humiliation," or "a flagrant bre[a]ch of a pledge of confidentiality which was instrumental in obtaining the personal information." *Id.* (quoting *Alexander v. Peffer*, 993 F.2d 1348, 1350 (8th Cir. 1993)). Dr. Hopkins contends that "[w]hen the information is inherently private, it is entitled to protection." *Id.* (quoting *Fraternal Order of Police, Lodge 5 v. City of Philadelphia*, 812 F.2d 105, 116 (3d Cir. 1987)).

Dr. Hopkins states that medical information is "considered extremely personal and entitled to protection under the fourteenth amendment." *Shuda v. Williams*, No. 4:08-cv-3168, 2008 WL 4661455, at *3 (D. Neb. Oct. 20, 2008) (finding that plaintiff stated a constitutional claim for disclosure of treating physicians and diagnoses). Dr. Hopkins also points to a Western District of Arkansas decision, *Bolt v. Doe*, in which the court stated "the right to informational privacy under the Fourteenth Amendment 'extends to medical test results, medical records, and medical communications. *See Ferguson v. City of Charleston*, 532 U.S. 67, 78, 121 S.Ct. 1281, 149 L.Ed.2d 205 (2001) (individuals have a reasonable expectation of privacy in medical test results and that those results will not be shared with nonmedical personnel without the patient's consent).' " Case No. 5:14-cv-5223, 2014 WL 5797706, at *5 (W.D. Ark. Nov. 7, 2014).

A district court in Kansas assessed a reporting statute that required reporting of all consensual underage sexual activity as sexual abuse. *See Aid For Women v. Foulston*, 427 F.Supp.2d 1093 (D. Kan. 2006), *overruled on other grounds by* Nos. 06–3187, 06–3188, 06–3202, 2007 WL 6787808 (10th Cir. 2007). The issue before that court was whether minor patients had a right to informational privacy concerning consensual sexual activity with an age-mate where there was no evidence of force, coercion, or power differential. That court reasoned that, "[an individual's right to informational privacy may be implicated when the government compels disclosure of that individual's personal sexual or health-related information to the government and/or to other third parties." *Id.*, at 1104.

Dr. Hopkins asserts that "[t]hese required disclosures under H.B. 2024 cause significant harm by exposing inherently private information, in breach of the confidential physician-patient relationship, to local police officers and others without any countervailing state interest" (Dkt. No. 3, 48). In response, defendants argue that Dr. Hopkins's claim that the Local Disclosure Mandate violates the right to informational privacy conflicts with the fact the neither the Eighth Circuit nor the Supreme Court has ever recognized this right (Dkt. No. 23, at 55). Defendants cite a number of cases in which the Eighth Circuit addresses a constitutional right to informational privacy but declines to find a violation of such a right. *See Alexander v. Peffer*, 993 F.2d 1348 (8th Cir. 1993); *Eagle*, 88 F.3d at 627; *Riley v. St. Louis Cty. of Mo.*, 153 F.3d 627, 631 (8th Cir. 1998); *Cooksey v. Boyer*, 289 F.3d 513, 516 (8th Cir. 2002). Defendants argue that "because the Eighth Circuit has never decided a case upholding a right to informational privacy, its discussions of various scenarios that fail to implicate that 'right' similarly do not establish the existence of such a right. *Cf. Kirtsaeng v. John Wiley & Sons, Inc.*, 568 U.S. 519, 133 S.Ct. 1351, 1368, 185 L.Ed.2d 392 (2013) ("[W]e are not bound to follow our dicta in a prior case in which the point now at issue was not fully debated.") (citation omitted) (inner quotation marks omitted)" (Dkt. No. 23, 56–57).

***54** Defendants argue that "in the absence of a clear indication by the Supreme Court that there is a right to informational privacy of constitutional dimensions, there are compelling reasons to forbear from finding that such a right exists" (Dkt. No. 23, 57). In the past, the Supreme Court has assumed that a constitutional right to informational privacy exists without actually making a finding as to its existence. *See NASA v. Nelson*, 562 U.S. 134, 131 S.Ct. 746, 178 L.Ed.2d 667 (2011); *Whalen v. Roe*, 429 U.S. 589, 97 S.Ct. 869, 51 L.Ed.2d 64 (1977); *Nixon v. Adm'r of General Servs.*, 433 U.S. 425, 97 S.Ct. 2777, 53 L.Ed.2d 867 (1977). In *Whalen*, the Supreme Court identified at least two kinds of constitutional privacy interests protected by the Fourteenth Amendment: avoiding disclosure of personal matters and independence in making certain kinds of important decisions. 429 U.S. 589, 599–600, 97 S.Ct. 869, 51 L.Ed.2d 64 (1977). Both the Supreme Court and district courts frequently cite *Whalen* for the prospect that the United States Constitution protects against the disclosure of personal matters. *See Bellotti*, 443 U.S. at 655, 99 S.Ct. 3035 (Rehnquist, J., concurring); *United States DOJ v. Reporters Comm. for Freedom of Press*, 489 U.S. 749, 762, 109 S.Ct. 1468, 103 L.Ed.2d 774 (1989); *Eagle*, 88 F.3d 620; *Alexander v. Peffer*, 993 F.2d 1348, (8th Cir. 1993); *Haid v. Cradduck*, No. 5:14-cv-5119, 2016 WL 3555032 at *5, 2016 U.S. Dist. LEXIS 82528 at *15 (W.D. Ark. June 24, 2016).

Numerous courts have recognized that confidential medical information is entitled to constitutional privacy protection in order to prevent the disclosure of such personal medical records. *See Cooksey*, 289 F.3d at 516; *A.L.A. v. West Valley City*, 26 F.3d 989, 990 (10th Cir. 1994); *U.S. v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980); *Haid v. Cradduck*, No. 5:14–cv–5119, 2016 WL 3555032, at *5, 2016 U.S. Dist. LEXIS 82528, at *15 (W.D. Ark. June 24, 2016); *Bolt v. Doe*, No. 5:14-cv-5223, 2014 WL 5797706 at *5, 2014 U.S. Dist. LEXIS 158304 at *11 (W.D. Ark. Nov. 7, 2014); *Shuda v. Williams*, No. 4:08CV3168, 2008 WL 4661455, at *3 (D. Neb. Oct. 20, 2008); *cf. Leher v. Bailey*, 2006 WL 1307658 (E.D. Ark. May 10, 2006).

Defendants point the Court to a number of Eighth Circuit decisions that find no violation of the right to informational privacy in support of defendants' argument that this protection does not exist (Dkt. No. 23, at 56–57). The Court will analyze those cases in turn. In *Alexander v. Peffer*, the Eighth Circuit held that to elevate remarks made about a woman's unsuccessful application to be a police officer to constitutional dimensions would trivialize the Fourteenth Amendment. 993 F.2d 1348, 1351 (8th Cir. 1993). In *Eagle v. Morgan*, the Eighth Circuit found

that the improper acquisition and unwarranted public disclosure of a man's expunged criminal record did not violate a constitutional right to privacy. 88 F.3d at 627. In *Riley*, the Eighth Circuit stated that because plaintiff allowed her son's remains to be viewed at the visitation, she had no legitimate expectation that information about her son's death or her son's remains would be kept confidential. 153 F.3d at 631. Finally, in *Cooksey*, the Eighth Circuit held that the disclosure of plaintiff's psychological treatment for stress did not reach the level of a constitutional violation. 289 F.3d 513. The Eighth Circuit recognized that all mental health information is not created equal and should not be treated categorically under a privacy rights analysis. *Id.*, at 517. The court went on to say that its holding was limited to the facts of the case and not intended to imply that unauthorized publication of any and all information relating to an individual's mental health is constitutionally permitted. *Id.*

The cases cited by defendants are distinguishable from the matter currently before this Court. Defendants are correct in their assertion that not every disclosure of personal information implicates the right against public disclosure of private information. The Eighth Circuit addressed this, stating "this protection against public dissemination of information is limited and extends to highly personal matters representing 'the most intimate aspects of human affairs.' " *Eagle*, 88 F.3d at 625. The Court acknowledges the high burden that applies to informational privacy claims. However, this case involves some of the most intimate and personal aspects of a woman's life. [15]

*55 Based on the law, the Court finds unpersuasive defendants' contention that the Constitution of the United States does not provide protection against disclosure of personal information, especially when such information rises to the level of an individual's most private and intimate affairs in the context of abortion regulation. At this stage of the case, the Court determines that Dr. Hopkins is likely to succeed on the merits of his informational privacy claim as it relates to the Local Disclosure Mandate and Non–CMA Teenage Patients.

3. Irreparable Harm

[59] In the absence of an injunction, Dr. Hopkins and the fraction of women for whom the Local Disclosure Mandate is relevant—Non–CMA Teenage Patients'—would be unduly burdened by the substantial obstacles created by the Local Disclosure Mandate, which lacks any justifying state purpose as applied to Non–CMA Teenage Patients. ***Whole Woman's Health***, 136 S.Ct. at 2309–10.

Enforcement of the Local Disclosure Mandate will inflict irreparable harm on Dr. Hopkins and his Non–CMA Teenage Patients as there is no adequate remedy at law. It is well-settled that the inability to exercise a constitutional right constitutes irreparable harm. *See Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury.") (citations omitted); *accord Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (quoting *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L.Ed.2d 547 (1976)).

In the absence of an injunction, Non–CMA Teenage Patients' ability to access abortion would be unduly burden by the substantial obstacles created by the Local Disclosure Mandate that lacks any justifying state purpose as applied to Non–CMA Teenage Patients. ***Whole Woman's Health***, 136 S.Ct. at 2309–10. Further, the Non–CMA Teenage Patients' right to informational privacy in the abortion context likely will be violated.

Therefore, the second requirement for an order preliminarily enjoining enforcement of the Local Disclosure Mandate is satisfied.

4. Balancing Of Harms

[60] In the absence of an injunction, Dr. Hopkins and the fraction of women for whom the Local Disclosure Mandate is relevant would be unduly burdened by the substantial obstacles created by the Local Disclosure Mandate, which lacks any justifying state purpose as applied to Non–CMA Teenage Patients. ***Whole Woman's Health***, 136 S.Ct. at 2309–10. Further, the Non–CMA Teenage Patients' right to informational privacy in the abortion context likely will be violated. Whereas, if an injunction issues, a likely unconstitutional law as applied to Non–CMA Teenage Patients passed by Arkansas legislators will not go into effect. The threatened harm to Dr. Hopkins and the Non–CMA Teenage Patients

clearly outweighs whatever damage or harm a proposed injunction may cause the defendants.

5. Public Interest

[61] It is in the public interest to preserve the *status quo* and to give the Court an opportunity to evaluate fully the lawfulness of the Local Disclosure Mandate without subjecting Dr. Hopkins, or his Non-CMA Teenage Patients, or the public to any of the law's potential harms.

It is therefore ordered that Dr. Hopkins's motion for preliminary injunction is granted to the extent that defendants are preliminarily enjoined from enforcing the provisions of Ark. Code Ann. § 12–18–108(a)(1); the Arkansas State Crime Laboratory Rules prescribed to implement the amended law, Ark. Admin. Code § 171.00.2 (2013); and Ark. Code Ann. § 12–18–103(c) which subjects a physician who violates Ark. Code Ann. § 12–18–108(a)(1) to license suspension or revocation and other disciplinary penalties, Ark. Code Ann. § 17–95–409 (2009).

D. Tissue Disposal Mandate (Counts X and XI based on H.B. 1566)

*56 Dr. Hopkins seeks a preliminary injunction based on the Tissue Disposal Mandate in count ten, which alleges that the tissue disposal mandate violates the Due Process Clause by placing an undue burden on Dr. Hopkins's patients' right to liberty and privacy, and count eleven, which alleges that the tissue disposal mandate violates the Due Process Clause due to its vagueness.

Currently, embryonic and fetal tissue generated from abortion and miscarriage is handled in a number of ways. Women who have medication abortions or complete miscarriage through medication dispose of the tissue at home. This is consistent with current Arkansas law that permits tissue passed at home, rather than at a medical facility, to be disposed of without being regulated. *See generally* Ark. Code Ann. § 20–32–101(1993) (governing disposal of commercial medicate waste); Ark. Code Ann. § 20–31–101(5) (defining "medical waste," in relevant part, as limited to "waste from healthcare-related facilities"); Ark. Code Ann. § 20–32–101(5)(A) (defining "pathological waste"); Ark. Code Ann. § 20–17–802(2015) (requiring disposal of tissue from abortion "in a fashion similar to that in which other tissue is disposed").

For surgical abortions, a contractor collects medical waste and embryonic or fetal tissue generated at the clinic and disposes of it out of state through incineration (Dkt. No. 6, ¶ 49). A few patients each year choose to have the tissue cremated, and those patients make arrangements with the cremation facility (*Id.*). Also, for a few patients each year, the tissue is sent to pathology labs to test for specific medical conditions or to determine the cause of the anomalies and the likelihood of recurrence in future pregnancies. In addition, following some abortions, tissue is preserved and made available to local law enforcement (Dkt. No. 6, ¶ 39). Before the Tissue Disposal Mandate was enacted, "fetal tissue" from abortion was defined as "human tissue"—which may be disposed of without regard to the Final Disposition Rights Act. Ark. Code Ann. §§ 20–17–801(a)(1)(A), 20–17–801(b)(2)(C).

The Tissue Disposal Mandate requires that a "physician or facility that performs an abortion shall ensure that the fetal remains and all parts are disposed of in accordance with § 20–17–801 and the Arkansas Final Disposition Rights Act of 2009, § 20–17–102." Ark. Code Ann. § 20–17–802(a). This law applies whether the embryonic or fetal tissue comes from abortion or miscarriage. The law subjects physicians violating it to criminal penalties, specifically those associated with Class A misdemeanors under Arkansas law. Ark. Code Ann. § 20–17–802(f).

The Arkansas Final Disposition Rights Act of 2009 ("FDRA") governs which family members have "[t]he right to control the disposition of the remains of a deceased person, the location, manner, and conditions of disposition." Ark. Code Ann. § 20–17–102(d)(1). Under the FDRA, if a decedent has not appointed anyone to control the final disposition of his or her remains, that right vests in individuals in the order the FDRA sets forth, including the decedent's spouse; child or children; parent or parents; and including other family members or, ultimately, a state government actor with the statutory obligation to arrange for the disposition of a decedent's remains. Ark. Code Ann. § 20–17–102(d)(1)(A)–(L). When the disposition right vests in a parent, and the other parent is "absent," that right vests solely in the remaining parent only after "reasonable efforts have been unsuccessful in locating the absent surviving parent." Ark. Code Ann. § 20–17–102(d)(1)(E)(ii). The

FDRA defines neither "absent" nor "reasonable efforts." Ark. Code Ann. § 20–17–102.

*57 The right to control the disposition of remains of a deceased person under the FDRA vests only in individuals who are 18 years old or older. Ark. Code Ann. § 20–17–102(d)(1). The right to control the disposition of remains of a deceased person under the FDRA also depends on the individual's willingness to assume liability for the costs associated with disposal and only if the individual "exercise[s] his or her right of disposition within two (2) days of notification of death of the decedent." Ark. Code Ann. § 20–17–102(e)(1)(B), (C). If there is a dispute among individuals who share equal disposition rights under the FDRA, the circuit court for the county decides to whom to award the disposition right. Ark. Code Ann. § 20–17–102(e)(2).

The FDRA defines "final disposition" as "the burial, interment, cremation, removal from Arkansas, or other authorized disposition of a dead body or fetus." Ark. Code Ann. § 20–17–102(2)(C). The FDRA does not define "other authorized disposition." A response with disposition rights also may "dispose of the remains in any manner that is consistent with existing laws, rules, and practices for disposing of human remains, including... cremat[ion]." Ark. Code Ann. § 20–17–102(i).

1. Likelihood Of Success On The Merits: Due Process Challenge

a. Applicable Law

[62] To determine whether Dr. Hopkins is likely to succeed on his challenge to the Tissue Disposal Mandate under the Due Process Clause, this Court applies the undue burden standard. In ***Whole Woman's Health***, the Supreme Court clarified that this undue burden analysis "requires that courts considers the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S.Ct. at 2309. The Supreme Court has determined that, to prevail, a plaintiff bringing a facial challenge must demonstrate that "in a large fraction of cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895, 112 S.Ct. 2791. To sustain a facial challenge and grant a preliminary injunction, this Court must make a finding that the Tissue Disposal Mandate is an undue burden for a large fraction of women for whom the law is relevant.

The law that controls the Court's evaluation of Dr. Hopkins's challenge to the Tissue Disposal Mandate under the Due Process Clause is set forth in more detail at Section IV.A.1.a. of this Order.

b. Analysis Of The Tissue Disposal Mandate

1. State's Interest

No legislative findings accompany the tissue disposal mandate. The Court does not have an explanation from the legislature of the purpose of the law. Defendants maintain that the tissue disposal mandate promotes the legitimate interests in "medical ethics" and "regulating the medical profession by ensuring that abortion clinics follow the same standards as other health care facilities that must dispose of fetal remains" and "demonstrating respect for the life of the unborn by requiring abortion providers to follow the same standards as other health care facilities that must dispose of fetal remains" (Dkt. No. 23, at 71). The Court assumes the legitimacy of these interests. ***Whole Woman's Health***, 136 S.Ct. at 2310 (assuming that the State had legitimate state interests where the statute did not contain any legislative findings).

2. Burdens Imposed On Women

Defendants cite to *Planned Parenthood of Minnesota v. State of Minnesota* and assert that a woman's right to abortion is not implicated by the Tissue Disposal Mandate. 910 F.2d 479 (8th Cir. 1990). The Minnesota statute examined in that case did not require notice and consent; it lacked any provision comparable to the FDRA. Further, the case was decided before *Casey* and before ***Whole Woman's Health***. The Court determines it is not controlling with regard to the facts presented here.

*58 Defendants also argue that the Tissue Disposal Mandate requires abortion providers to make "the same arrangements that all other healthcare providers are required to make for human remains." (Dkt. No. 23, at 72). Defendants cite no authority for this, and there is no evidentiary support in the record for this contention.

The FDRA itself imposes no obligations on healthcare providers; the Tissue Disposal Mandate is the first time the FDRA has been applied to a healthcare provider and then only to a "physician or facility that performs an abortion" in the context of abortion and miscarriage. Ark. Code Ann. § 20–17–802(a). Prior to the Tissue Disposal Mandate, the FDRA applied to the disposition of human remains for individuals and their family members and established protections for funeral homes and crematoria when those entities relied on information regarding disposition provided by family members. Ark. Code Ann. § 20–17–102(d)(1), (f)(2).

Here, the Tissue Disposal Mandate requires notice and consent to the disposition of embryonic and fetal tissue—and of every woman's abortion—from a woman's sexual partner or, if the woman and her sexual partner are minors, the parent or parents of both, in direct conflict with Supreme Court precedent. *See Casey*, 505 U.S. at 893–94, 112 S.Ct. 2791 (examining spousal notification); *Hodgson v. Minnesota*, 497 U.S. 417, 110 S.Ct. 2926, 111 L.Ed.2d 344 (1990) (examining parental consent and required judicial bypass); *Bellotti*, 443 U.S. at 622, 99 S.Ct. 3035 (same).

That fact that both "parents" have disposition rights under the FDRA creates a requirement of notice and consent of the woman's sexual partner and requires that, when the other "parent" is "absent," then "reasonable efforts" need to be made to locate him prior to disposition. Ark. Code Ann. 20–17–102(d)(1)(E). The FDRA does not define "reasonable efforts."

This notice and consent requirement of a woman's sexual partner directly violates binding Supreme Court precedent. *See Danforth*, 428 U.S. at 69, 96 S.Ct. 2831 ("[T]he State may not constitutionally require consent of the spouse... as a condition for abortion...."); *Casey*, 505 U.S. at 898, 112 S.Ct. 2791 (invaliding a provision requiring spousal notification prior to abortion); *see also id.* ("A husband has no enforceable right to require a wife to advise him before she exercises her personal choices," including about pregnancy.).

That the woman's sexual partner could be difficult to locate, could withhold consent, could seek a different means of disposition, or could otherwise delay the abortion gives him "an effective veto" over her decision. *Casey*, 505 U.S. at 897, 112 S.Ct. 2791. Notice of abortion could subject some women to physical and psychological abuse. *Casey*, 505 U.S. at 893, 112 S.Ct. 2791. (Dkt. No. 5, ¶¶ 56–57; Dkt. No. 6, ¶ 60). Therefore, the Tissue Disposal Mandate burdens all women seeking abortions by virtue of this notice requirement and is "likely to prevent a significant number of women from obtaining an abortion." *Casey*, 505 U.S. at 893, 112 S.Ct. 2791.

Defendants asserts that "the right to decide how to dispose of the [embryonic and fetal tissue] vests in the parents of the deceased child." (Dkt. No. 22, at 58). The law provides "that if the father is absent, the mother is vested with the rights of disposition after reasonable efforts are unsuccessful in locating the father." (Dkt. No. 22, at 58). However, defendants maintain that "this section plainly does not require that any efforts be made to notify the father or to obtain his consent." (Dkt. No. 22, at 58). Instead, defendants propose that, if no action is taken for five days, " 'if any person'—including the father of the deceased child—does not exercise his disposition right within five days of the death, he forfeits that right." (Dkt. No. 22, at 58). And then "the right of disposition vests solely in the mother, and her wishes for the disposition of the fetal remains control." (Dkt. No. 22, at 58).

The woman alone is vested with the right to disposition only after reasonable efforts have been unsuccessful in locating the "father." Ark. Code Ann. 20–17–102(d)(1)(E)(ii). Defendants appear to suggest that efforts could be undertaken to locate the other "parent," but that nothing more is necessary under the statute and that, if found, the other "parent" need not be notified of his disposition right. As Dr. Hopkins observes, this reading of the Tissue Disposal Mandate would require "a physician or his patient" to "engage in a search of an undefined time, but for no ultimate purpose." (Dkt. No. 32, at 62). The Court rejects this reading of the Tissue Disposal Mandate. In construing the law narrowly to avoid constitutional doubts, the Court "must also avoid a construction that would seriously impair the effectiveness of [the law] in coping with the problem it was designed to alleviate." *See Harriss*, 347 U.S. at 623, 74 S.Ct. 808.

***59** Defendants also contend that other provisions of the law cause the right "to vest solely in the mother even sooner." (Dkt. No. 22, at 58). Defendants point to the provision that states, if the "father" is "unwilling to assume the liability for the costs" of disposition, then the right vests solely and immediately in the mother. Ark.

Code Ann. 20–17–102(e)(1)(C). As Dr. Hopkins points out, "to convey an unwillingness to assume the cost of disposition, one would have to be notified of his right in the first place" which implicates the notice requirements he challenges as unconstitutional (Dkt. No. 32, at 66).

Defendants maintain that, if the father is " 'estranged'—meaning a 'physical and emotional separation from the decedent at the time of death which has existed for a period of time that clearly demonstrates an absence of due affection, trust, and regard for the decedent'—then the disposition right vests solely in the mother immediately." (Dkt. No. 22, at 58) (citing Ark. Code Ann. 20–17–102(e)(1)(D)(ii)). The Court agrees with Dr. Hopkins that there is no explanation for how a physician would know whether a woman's sexual partner was "estranged" from the "decedent," which are defined terms under the Tissue Disposal Mandate (Dkt. No. 32, at 66). There is no safe harbor for a physician to rely on a woman's representation that the other parent is "estranged" from the "decedent" or unwilling to assume the costs of disposition and avoid the Mandate's penalties. To read such a provision into the FDRA would be difficult because the FDRA specifically includes a safe harbor provision stating that a "funeral establishment, cemetery, or crematory shall have the right to rely on" a signed funeral service contract or authorization, and "shall have the authority to carry out the instructions of the person or persons whom the funeral home, cemetery, or crematory reasonably believes holds the right of disposition." Ark. Code Ann. § 20–17–102(f)(2). There is no comparable provision for Dr. Hopkins or other abortion providers. The Court finds the statutory canon of *expressio unius est exclusio alterius*—the expression of one is the exclusion of others—applicable on these facts. This canon, like all rules of construction, is applicable under certain conditions to determine the intention of the lawmaker when it is not otherwise manifest. Here, the state explicitly provided a safe harbor provision in the FDRA for funeral establishments, cemeteries, and crematoriums, but declined to provide a safe harbor provision pertaining to abortion providers in the Tissue Disposal Mandate.

In the case of a minor woman, if her sexual partner was at least 18, then he would control disposition under the FDRA. Ark. Code Ann. § 20–17–102(d)(1), (d)(1)(E). This implicates the same constitutional concerns cited in regard to notification of sexual partners. If a minor woman's sexual partner was also a minor, then the woman's parents and her partner's parents would control disposition under the FDRA. Ark. Code Ann. § 20–17–102(d)(1), (d)(1)(G). This would necessitate notice to the woman's parents and her partner's parents of the woman's intent to have an abortion.

This requirement effectively circumvents Arkansas's constitutionally mandated judicial bypass process. Current law requires that a physician obtain the written consent of one parent before providing abortion care to a minor patient. Ark. Code Ann. § 20–16–804. The law also provides that a court may authorize the minor to consent to the abortion without the consent of her parent. Ark. Code Ann. §§ 20–16–808, 20–16–809. The availability of the judicial bypass process reflects long-standing constitutional requirements. *Bellotti*, 443 U.S. at 643, 99 S.Ct. 3035 ("[I]f the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained."); *Id.*, at 639–40, 99 S.Ct. 3035 ("[A] State [can] not lawfully authorize an absolute parent veto over the decision of a minor to terminate her pregnancy.")(citing *Danforth*, 428 U.S. at 74, 96 S.Ct. 2831)).

***60** Defendants claim that this law does not require a minor's parents be involved, regardless of whether she has obtained a judicial bypass. Defendants rely on language that states, in the "absence" of any person qualified under the statute to exercise the disposition right, "any other person" who is willing to act may exercise the right, Ark. Code Ann. § 20–17–102(d)(2), to argue that a minor who has obtained a judicial bypass may act without involving parents. (Dkt. No. 22, at 58). Under the FDRA no one under the age of 18 has the right to control disposition, so defendants are incorrect on this point. Ark. Code Ann. § 20–17–102(d)(1). Further, the provision upon which defendants rely applies only after no one else is willing to exercise a disposition right. This provision of the FDRA requires that a person exercising a right under § 20–17–102(d)(2), which is the provision upon which defendants rely to make this argument invoking judicial bypass, "attest[ ] in writing that a good faith effort has been made to no avail to contact the individuals under this subsection." Ark. Code Ann. § 20–17–102(d)(2). These requirements thwart defendants' claim regarding judicial bypass.

Dr. Hopkins contends that he cannot provide care without first knowing that the tissue can be disposed of lawfully (Dkt. No. 3, at 23). Therefore, the law requires that he notify at least one, and perhaps more than one, third party before every woman's abortion. The law mandates disclosure to a woman's partner or spouse, even if that person is no longer in her life or is a perpetrator of sexual assault. For minor women, it bypasses the State's constitutionally mandated judicial bypass process, through which a minor can choose not to involve her parent in her abortion decision and instead obtain judicial authorization. The FDRA potentially expands disclosure to all four parents—those of the woman and those of her sexual partner. Dr. Hopkins argues that these forced disclosures alone are enough to interfere severely with abortion care (Dkt. No. 3, at 23). *See, e.g., Casey*, 505 U.S. at 894, 112 S.Ct. 2791 ("[A] significant number of women... are likely to be deterred [by a spousal notification requirement] from procuring an abortion as surely as if the [State] had outlawed abortion in all cases.") (Dkt. No. 5, ¶¶ 56–57; Dkt. No. 6, ¶ 61). There is no evidence in the record before the Court to contradict Dr. Hopkins's assertions regarding compliance with the Tissue Disposal Mandate.

What defendants may not do directly they also may not do indirectly. The Tissue Disposal Mandate gives a parent or others "an absolute, and possible arbitrary, veto" over a minor's decision to have an abortion. *Danforth*, 428 U.S. at 74, 96 S.Ct. 2831; *see also Bellotti*, 443 U.S. at 639–40, 644, 99 S.Ct. 3035. The Tissue Disposal Mandate requires a minor to disclose her decision to both parents, in some instances risking her health and safety by doing so. *See Hodgson*, 497 U.S. at 450–451, 110 S.Ct. 2926. The Tissue Disposal Mandate goes even further by requiring, under certain circumstances, the involvement of the woman's sexual partner's parents, and others even further removed from the woman, under certain circumstances. These requirements cannot be reconciled with binding Supreme Court precedent.

The Tissue Disposal Act imports the FDRA's disclosure and decision-making requirements—originally enacted to provide a framework for disposition of human remains by family members—to the disposition of embryonic and fetal tissue. The Tissue Disposal Mandate will dissuade and delay women who seek abortions and also, as a practical matter based on the record evidence before this Court, make it impossible for Dr. Hopkins to continue providing abortions because he cannot ensure that tissue disposition will ultimately take place in compliance with the FDRA, subjecting him to criminal sanctions. To avoid criminal penalties, Dr. Hopkins takes the position that he will have no choice but to cease providing abortions if the Tissue Disposal Mandate takes effect (Dkt. No. 5, ¶ 61). *See **Whole Woman's Health***, 136 S.Ct. at 2313 (examining the undue burden resulting from closure of abortion facilities).

***61** Compliance with the law requires that within each class of decision-makers, present class members "used reasonable efforts to notify" others and that any dispute is resolved by a vote of the class members or a proceeding before the circuit court. Ark. Code Ann. § 20–17–102(d)(1)(E), (d)(1)(G), (e)(2). The notice and search requirements for interested parties under the Tissue Disposal Mandate will cause significant delay that would result in harm to women seeking abortion care (Dkt. No. 5, ¶¶ 58, 61). Delay increases the risks associated with pregnancy-related care, can deny a woman her choice of abortion procedure, and if she is pushed past the clinic's gestational limit, can make it impossible for her to obtain an abortion in Arkansas. *See, e.g., Schimel*, 806 F.3d at 920; *Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley*, 2016 WL 6211310, at *29.

Further, because the phrase "in any manner that is consistent with existing laws, rules, and practices for disposing of human remains" is undefined, it is not clear as to what acceptable methods of disposition might be selected. Ark. Code Ann. § 20–17–102(d)(2), (e)(2). The FDRA also requires that only those willing to pay the cost of disposition have a say in the plan. Ark. Code Ann. § 20–17–102(e)(1)(C). Dr. Hopkins argues that ascertaining and documenting the fact that a person with a disposition right forfeits input due to a lack of willingness or resources to assume financial responsibility may be difficult or impossible for Dr. Hopkins (Dkt. No. 3, at 24). The notice, search, and documentation requirements for interested parties under the Tissue Disposal Mandate will cause significant delay and will harm women seeking abortion care (Dkt. No. 5, ¶¶ 58, 61).

It would be a burden on Dr. Hopkins and his clinic to set up systems sufficient and timely enough to ensure that all requirements of the FDRA are met before Dr. Hopkins provides abortion care (Dkt. No. 5, ¶ 58; Dkt. No. 6, ¶¶ 50–51, 55–56, 59, 62). *See **Whole Woman's***

Health, 136 S.Ct. at 2318 (examining, in the context of the undue burden analysis, the cost of complying with the new regulation). Proceeding with abortion care without knowing that the requirements of the FDRA have been met subjects Dr. Hopkins to criminal penalties.

It also is unclear whether at-home disposal of tissue following medication abortion or treatment of miscarriage is permitted under the FDRA (Dkt. No. 3, at 24). Defendants claim that this law does not ban medication abortions used during the first trimester, arguing the law "expressly applies only to a 'physician or facility that performs an abortion.' " (Dkt. No. 60). Defendants argue this phrase does not apply "to a woman taking a pill in the comfort of her home pursuant to a medication-abortion procedure." (Dkt. No. 22, at 60). Under Arkansas law, medication abortion must be performed by a physician. Ark. Code Ann. § 5–61–101 (crime for anyone other than licensed physician to perform abortion); Ark. Code Ann. § 20–16–603(b)(1) (physician-only law for medication abortion).

Dr. Hopkins faces criminal penalties if he fails to dispose properly of tissue following a medication abortion or treatment of miscarriage. Absent certainty on these points, Dr. Hopkins maintains that he will have to stop providing medication abortion (Dkt. No. 5, ¶ 55; Dkt. No. 6, ¶ 52). Regardless if the Tissue Disposal Mandate applies to medication abortion or not, that fact does not change the Court's ultimate conclusion regarding the constitutionality of the Mandate.

On July 20, 2017, defendants submitted supplemental authority in support of their opposition to Dr. Hopkins's motion for preliminary injunction (Dkt. No. 31). Defendants state that, on July 20, 2017, "the Arkansas Legislative Council approved an amended rule concerning the disposition of fetal remains. The amended rule, which is attached to this notice as Exhibit A, defines 'dead fetus or fetal remains' and provides that each facility shall ensure that each dead fetus or fetal remains are disposed of in accordance with Ark. Code. Ann. § 20–17–102." (Dkt. No. 31, at 1). Defendants contend that "[t]he amendments to Agency Rule # 007.05 expressly provide that the requirements for the disposition of fetal remains under Ark. Code Ann. § 20–17–102 do not apply to medication abortions: 'The requirements of this subsection shall not apply to abortions induced by the administration of medications when the evacuation of any human remains occurs at a later time and not in the presence of the inducing physician nor at the facility in which the physician administered the inducing medications.' Exh. A at 6–3 ¶ 6.O.1." (*Id.*).

*62 The Court is unclear on the authority possessed by the Legislative Council and, therefore, unclear on the binding nature of this amendment to the Tissue Disposal Mandate. The Court also questions whether this amendment has to go through an approval process before being formally adopted. The Court has reviewed the website of the Arkansas State Legislature for further guidance; that provides no clarity. *See* http://www.arkleg.state.ar.us/assembly/2011/2012F/pages/CommitteeDetail; *see* also Andy Davis, *Board Approves Rule to Clarify Arkansas Abortion Law*, Arkansas Democrat Gazette, Jul. 20, 2017, at 1, *available at* http://www.arkansasonline.com/news/2017/jul/20/board-approves-rule-to-clarify-abortion/.

The Court has reviewed thoroughly the amendment attached as Exhibit A to the supplemental authority. The Court concludes that, even if it had proof that this amended rule was the final, approved-of, form, the change does not make the Tissue Disposal Mandate constitutional. As a result, the Court will take note of the amendment, but the Court concludes as a matter of law that it does not alter the analysis as to the constitutionality of the Mandate.

Further, under the law, Dr. Hopkins maintains that he must ensure disposition under the FDRA's requirements even if such tissue is sent to a pathology lab. Dr. Hopkins cannot control how a pathology lab disposes of tissue after testing, but this law purports to subject Dr. Hopkins to criminal liability based on the actions of third parties who receive the tissue for reasons other than disposition (Dkt. No. 5, ¶ 60; Dkt. No. 6, ¶ 53). The Tissue Disposal Mandate puts Dr. Hopkins in a position of not sending tissue when it is important for women's health or risking criminal liability under the Tissue Disposal Mandate.

Defendants claim that "a fetal tissue sample sent to a pathology lab would fall under the definition of 'human tissue' in Ark. Code Ann. § 20–17–801(b)(2)(C), and can be disposed of 'in a respectful and proper manner' under the statute." (Dkt. No. 22, at 60). Therefore, defendants argue that Dr. Hopkins would not face criminal liability for sending fetal tissue for pathological testing, even if he

could not assure that the pathology lab would dispose of fetal tissue as required by the Tissue Disposal Mandate (Dkt. No. 22, at 60). The Tissue Disposal Mandate amended Ark. Code Ann. § 20–17–801(b)(2)(C) to remove "fetal tissue" from the definition of "human tissue," making that means of disposal impermissible for fetal tissue.

Dr. Hopkins also cannot control how law enforcement disposes of tissue. However, Dr. Hopkins maintains that he arranges the transport of tissue to law enforcement "consistent with existing laws," Ark. Code Ann. § 20–17–102(i), and accordingly understands the disposition to be consistent with the FDRA (Dkt. No. 3, at 25 n.11).

The Court determines these burdens support facial invalidity of the Tissue Disposal Mandate. The Court will premise its analysis on defendants' contention that the Mandate applies to all non-medication abortions. The notice provision impermissibly burdens women over the age of majority or under the age of majority with a partner over the age of majority who seek a non-medication abortion by requiring notice to the other "parent," meaning the woman's spouse or partner. The notice provision impermissibly burdens women who are minors with minor partners who seek non-medication abortions by requiring notice to the parent or parents, including notice to the partner's parents.

The Court cannot apply the defendants' suggested workarounds to the notice provisions in an effort to construe the Tissue Disposal Mandate as constitutional for the reasons stated. The workarounds are not supported by the text of the Tissue Disposal Mandate.

3. Balancing

*63 Dr. Hopkins asserts that, while the burdens of the Tissue Disposal Mandate are many and substantial, it advances no valid interest in a permissible way. He contends that any interest the State of Arkansas has in disposition of embryonic and fetal tissue in a medically appropriate way is sufficiently advanced by current law. *See Whole Woman's Health*, 136 S.Ct. at 2311, 2314 (finding no significant problem that the new restriction "helped to cure," nor was it "more effective than pre-existing [state] law" in advancing state's asserted interest). The Tissue Disposal Mandate does not specify any new method of disposal. Instead, it only imposes the FDRA's complex requirements for authorization of disposal that are separate and apart from the method, and it applies those only to a "physician or facility that performs an abortion" in the context of abortion and miscarriage. Ark. Code Ann. § 20–17–802(a). Dr. Hopkins is likely to succeed on this argument.

For these reasons, the Court is not convinced that importing the FDRA's complex requirements for authorization advances a public health goal. These requirements also do not advance interests in women's health because delay and other negative effects instead threaten women's health and wellbeing. Neither can any interest the State has in potential life support the Tissue Disposal Mandate because it applies to tissue disposal after an abortion or miscarriage, when there is no "potential life." *See Whole Woman's Health*, 136 S.Ct. at 2314 ("Unlike legitimate state interests recognized by the Supreme Court, [Texas's] professed interest regulates a time when there is no potential life."); *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r*, 194 F.Supp.3d 813, 833 (S.D. Ind. 2016) ("interest in potential life has not been extended... to imposing procedures taken after the pregnancy has been terminated like the fetal tissue disposition provisions do" (internal quotation marks and citations omitted)).

Weighing the burdens against the Tissue Disposal Mandate's state interests, if any, and the marginal way the Tissue Disposal Mandate advances those state interests, if at all, the Court concludes that Dr. Hopkins is likely to prevail on his claim that in a large fraction of cases in which the Tissue Disposal Mandate is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion. The record includes sufficient evidence from which Dr. Hopkins satisfies his burden to present evidence of causation that the Mandate's requirements will lead to this effect. *See Whole Woman's Health*, 136 S.Ct. at 2313.

4. Women Effected

To sustain a facial challenge and grant a preliminary injunction, this Court must make a finding that the Tissue Disposal Mandate is an undue burden for a large fraction of women the Mandate impacts. If the Mandate is construed as defendants assert, meaning that the Mandate

does not apply to medication abortion, the numbers the Court will discuss may change slightly. The end result will not.

In Arkansas, 3,771 abortions were performed in 2015 (Dkt. No. 5, Ex. B, at 36). Of those, 581 were medication abortion and 3,190 were not. Of the 3,771 total abortions in 2015 in Arkansas, 528 were obtained by married women, and 3,234 were obtained by not married women (*Id.*). Nine individuals reported "unknown" when asked marital status (*Id.*). Of the 3,771 total abortions in 2015 in Arkansas, 141 were obtained by individuals below the age of 18 (*Id.*).

As explained, the Tissue Disposal Mandate requires notice and consent to the disposition of embryonic and fetal tissue—and of every woman's abortion—from a woman's sexual partner or, if the woman and her sexual partner are minors, the parent or parents of both. There is no judicial bypass procedure for a minor, as this Court is unable to adopt defendants' argument advancing one. The denominator for this Court's analysis of women impacted by the Mandate is either 3,771 total abortions or 3,190 total non-medication abortions. Regardless, the numerator equals the denominator in this fraction. To comply with the Tissue Disposal Mandate, all women seeking abortions must notify their sexual partner or, if both the woman and her sexual partner are minors, the women must notify the parent or parents of both.

***64** Lower court judges are bound by Supreme Court precedent, even if they seriously question what the Court has done. *MKB Management Corp. v. Stenehjem*, 795 F.3d 768 (8th Cir. 2015). The lower federal courts cannot second-guess the Supreme Court regarding "underlying facts." *Id.*, at 772. On the record before this Court, there is no basis upon which to revisit the holdings in *Casey*, *Hodgson*, and *Bellotti*, along with other consistent precedent, regarding the undue burden imposed by the types of notification requirements in the Tissue Disposal Mandate. This is especially true here where the interests the State advances in support of the Mandate are not as compelling as those interests advanced in *Casey*, *Hodgson*, *Bellotti*, and other consistent precedent. It is also true where, as here, there is no factual basis in the record upon which this Court could question or revisit the underlying factual determinations made by the Supreme Court in those cases.

In *Casey*, this spousal notification law at issue provided that, "except in cases of medical emergency, that no physician shall perform an abortion on a married woman without receiving a signed statement from the woman that she has notified her spouse that she is about to undergo an abortion. The woman has the option of providing an alternative signed statement certifying that her husband is not the man who impregnated her; that he husband could not be located; that the pregnancy is the result of spousal sexual assault which she has reported; or that the woman believes that notifying her husband will cause him or someone else to inflict bodily injury upon her. A physician who performs an abortion on a married woman without receiving the appropriate signed statement will have his or her license revoked, and is liable to the husband for damages." *Casey*, 505 U.S. at 887–88, 112 S.Ct. 2791. The Court laid out the factual findings "supported by studies of domestic violence." *Id.*, at 891, 112 S.Ct. 2791.

The Court then concluded that "[t]he spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle. We must not blind ourselves to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases." *Id.* at 893–94, 112 S.Ct. 2791.

Defendants in *Casey* attempted to avoid that conclusion by arguing the spousal notification law imposed almost no burden at all for the vast majority of women seeking abortions. "They begin by noting that only about 20 percent of the women who obtain abortions are married. They then note that of these women about 95 percent notify their husbands of their own volition. Thus, respondents argue, that the effects of [the spousal notification law] are felt by only one percent of the women who will be able to notify their husbands without adverse consequences or will qualify for one of the exceptions, the statute affects fewer than one percent of women seeking abortions." *Id.* at 894, 112 S.Ct. 2791. Defendants relied upon this argument to claim the statute could not be "invalid on its face." *Id.*

The Court rejected this argument, stating "[t]he analysis does not end with the one percent of women upon whom

the statute operates; it begins there.... The proper focus of the constitutional inquiry in the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* The Court determined that "[t]he unfortunate yet persisting conditions that we document above will mean that in a large fraction of the cases in which [the spousal notification law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion. It is an undue burden, and therefore invalid." *Id.*, at 895, 112 S.Ct. 2791.

*65 In a five to four plurality decision in *Hodgson*, the Supreme Court concluded that, standing by itself, a provision of a Minnesota statute requiring that no abortion be performed on a woman under 18 years of age until at least 48 hours after both of her parents had been notified, except where an immediate abortion was necessary to prevent the woman's death or where the woman declared that she was a victim of parental abuse or neglect, and except where notification of only one parent is necessary because the second parent is dead or cannot be located through reasonably diligent effort, was unconstitutional as violating Fourteenth Amendment due process guaranties, since insofar as the statute required both parents to be notified, it did not reasonably further any legitimate state interest. *Id.*, at 452–454, 110 S.Ct. 2926. In assessing the alleged state interest, the Court noted that a two-parent notification requirement would be harmful to some minors and their families, thereby doing a disservice to the state's interest in protecting and assisting minors. *Id.*, at 451, 110 S.Ct. 2926.

The Court reasoned that the state had no legitimate interest in conforming family life to a state-designed ideal by requiring family members to talk together, nor could the state's interest in protecting a parent's interest in shaping a child's values and lifestyle overcome the liberty interests of a minor acting with the consent of a single parent, or a court. *Id.*

However, a majority of the justices were of the opinion that the challenged Minnesota statute avoided constitutional infirmity because it contained an adequate judicial procedure for bypassing the parental notification requirement—that is, a provision that a court of competent jurisdiction could, in a confidential proceeding, authorize an abortion without parental notification upon determining that the minor is mature and capable of giving informed consent, or that an abortion without notice to both parents would be in the minor's best interest, and the Court accordingly affirmed a judgment holding the statute, with the judicial bypass procedure, constitutional. *See also Bellotti*, 443 U.S. at 622, 99 S.Ct. 3035 (standing for the proposition that a parental consent law is constitutional if it provides for a sufficient judicial bypass alternative).

If the Mandate is construed as Dr. Hopkins contends, then the Tissue Disposal Mandate applies to all abortions in Arkansas. Accepting defendants' argument regarding scope, the Mandate would not bar medication abortion in Arkansas, but it would still impose the impermissible notification requirements. The Court finds as a matter of law that Dr. Hopkins is likely to succeed on his claim that the Tissue Disposal Mandate is an undue burden for a large fraction of the women impacted by the Mandate, regardless of how the Court construes the Mandate.

Even if the notification requirements are not alone sufficient to constitute an undue burden, and this Court determines it is bound to apply controlling precedent to conclude that they are, there are other undue burdens imposed by the Tissue Disposal Mandate that lead the Court to conclude Dr. Hopkins is likely to succeed on the merits. Dr. Hopkins takes the position that, to avoid criminal penalties, he will have no choice but to cease providing abortions if the Tissue Disposal Mandate takes effect (Dkt. No. 5, ¶ 61). *See **Whole Woman's Health***, 136 S.Ct. at 2313 (examining the undue burden resulting from closure of abortion facilities). Little Rock Family Planning Services, along with Dr. Hopkins, provides care to women from throughout Arkansas and from other states (Dkt. No. 6, ¶ 5). Dr. Hopkins is aware of no physicians, other than those with whom he practices at Little Rock Family Planning Services, who provide second trimester or surgical abortion care (Dkt. No. 32–2, ¶ 2). The only other provider in Arkansas provides medication abortion through 10 weeks LMP in Little Rock and Fayetteville (Dkt. No. 5, ¶ 6). In other words, there are no other providers in Arkansas that could fill this gap in care.

*66 Many patients of Little Rock Family Planning Services are low-income. Approximately 30 to 40% of patients obtain financial assistance to pay for their abortion care (Dkt. No. 6, ¶ 5). Many patients of Little Rock Family Planning Services struggle in their lives and in their efforts to access the medical care they need (Dkt. No. 6, ¶ 5). The time and effort it takes to make the

necessary plans to access medical care cause anxiety and stress and cause financial pressure for women seeking care at Little Rock Family Planning Services (Dkt. No. 6, ¶ 8). These findings, coupled with the finding that abortions other than medication abortions would essentially be unavailable in the State of Arkansas if the Tissue Disposal Mandate takes effect, bolster this Court's conclusion that if the Tissue Disposal Mandate takes effect a large fraction of Arkansas women who select non-medication abortion throughout the first and second trimesters would experience a substantial obstacle to abortion.

Attempting to comply with the notice and search requirements for interested parties under the Tissue Disposal Mandate will cause significant delay that will result in harm to women seeking abortion care (Dkt. No. 5, ¶¶ 58, 61). Delay increases the risks associated with pregnancy-related care, can deny a woman her choice of abortion procedure, and if she is pushed past the clinic's gestational limit, can make it impossible for her to obtain an abortion in Arkansas. *See, e.g., Schimel*, 806 F.3d at 920; *Jegley*, 2016 WL 6211310, at *29.

There likely would be additional costs associated with abortion care if the Tissue Disposal Mandate were to take effect and if there were a non-medication abortion provider in Arkansas, due to the increased burden of administrative costs to be incurred by the provider in setting up systems to attempt to comply with the notice provisions, document compliance, and document the fact that a person with a disposition right forfeits input due to a lack of willingness or resources to assume financial responsibility (Dkt. No. 5, ¶ 58; Dkt. No. 6, ¶¶ 50–51, 55–56, 59, 62). *See Whole Woman's Health*, 136 S.Ct. at 2318 (examining, in the context of the undue burden analysis, the cost of complying with the new regulation). All of these burdens inform this Court's finding that the Tissue Disposal Mandate imposes an undue burden on the fraction of women for whom the statute is relevant.

2. Likelihood Of Success On The Merits: Vagueness

[63] The Tissue Disposal Mandate requires physicians to ensure that embryonic and fetal tissue is disposed of in accordance with the FDRA and that physicians must ensure that outcome, but, Dr. Hopkins contends that the requirements of the FDRA as applied to abortion and miscarriage management leave many critical questions unanswered. He challenges the Tissue Disposal Mandate as void for vagueness. Specifically, Dr. Hopkins contends that H.B. 1566, "including its incorporation of the FDRA, is impermissibly vague in at least two respects: first, whether tissue resulting from a medication abortion or following miscarriage care may be disposed of by the patient at home, and, second, what, if any, obligations are imposed on women seeking abortion and miscarriage care and/or Plaintiff regarding 'reasonable efforts' to locate an 'absent' 'parent' or 'other members of the class' of 'grandparents.' Ark. Code. Ann. §§ 20–17–102(d)(1)(E), (d)(3)(B)." (Dkt. No. 3, at 53).

Dr. Hopkins further argues that "while the FDRA appears to concern the "[f]inal disposition' of 'a dead body or fetus,' *id.* § 20–17–102(a)(2)(C), its various references to 'human remains,' *id.* §§ 20–17–102(b)(1)(A), (c), (h), (i), (j), are unclear, because H.B. 1566 now uses 'fetal remains' to refer to tissue disposition after abortion, *see* H.B. 1566 § 3. Given the potential liability for violating H.B. 1566, plaintiff cannot make good faith efforts to comply and hope for the best. Rather, Dr. Hopkins is faced with uncertainty that will require him to curtail services." (Dkt. No. 3, at 58).

***67** The FDRA addresses methods of disposition in three provisions. As noted, the statute defines "final disposition" to include "burial, interment, cremation, removal from Arkansas, or other authorized disposition of a dead body or fetus," Ark. Code Ann. § 20–17–102(a)(2)(C), gives a person with disposition rights the authority to control "the disposition of the remains of a deceased person, the location, manner, and conditions of disposition," *id.*, § 20–17–102(d)(1); and also authorizes a person with disposition rights, in the absence of a declaration of final disposition by the decedent, to "dispose of the remains in any manner that is consistent with existing laws, rules, and practices for disposing of human remains, including ... cremat[ion]," *id.* § 20–17–102(i). Dr. Hopkins contends that these civil provisions are not drafted with the precision necessary to provide him or enforcement authorities with "fair notice of conduct that is forbidden or required." *Fed. Commc'ns Comm'n v. Fox Television Station, Inc.*, 567 U.S. 239, 253, 132 S.Ct. 2307, 183 L.Ed.2d 234 (2012).

Dr. Hopkins also notes that "[t]he lack of clarity as to a physician's obligations under the FDRA [is] compounded by the fact that § 20–17–802 of the Arkansas Code,

which imposes criminal penalties, contains no scienter requirement and appears to be a strict liability offense." *See Stivers v. State*, 354 Ark. 140, 118 S.W.3d 558 (2003) (offense outside the criminal code, which contained no *mens rea* requirement, in the absence of legislative intent to include one, was a strict liability offense). *See also Stahl v. City of St. Louis, Missouri*, 687 F.3d 1038, 1041 (8th Cir. 2012) (lack of *mens rea* requirement 'further demonstrate[s]' vagueness)." (Dkt. No. 3, at 55, n. 16).

Dr. Hopkins states that "this vagueness gives [him] no option but to stop providing care, and will impermissibly deprive his patients of access to abortion and miscarriage care, including the safe and accepted method of medication abortion and disposition of the tissue at home." *See Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1465, 1467 (8th Cir. 1995). Defendants argue that, "the requirements for the disposition of 'human tissue' are clearly set forth in a portion of the statute that he does not challenge, Ark. Code Ann. § 20–17–801. For its part, the Final Disposition Rights Act is also clear, providing detailed instructions for determining who has the right to dispose of a dead child's body. Ark. Code Ann. § 20–17–102. For these reasons, Hopkins cannot show that he is likely to prevail on a vagueness challenge to Act 603." (Dkt. No. 23, at 75–76.). The Court notes that the discussion of the potential Legislative Council amendment to the Tissue Disposal Mandate could remedy the vagueness in this section of the Tissue Disposal Mandate. However, as stated, the Court has no information in the record to determine the authority if that decision-making body or to determine whether the amendment is final. Even if the amendment remedies the vagueness as to the types of tissue that must be disposed, the Court finds that the other sections of the Mandate are still unconstitutionally vague. Dr. Hopkins has no way of knowing from the Mandate the definitions of "reasonable efforts" to locate an "absent" parent or "grandparent," as required by the Mandate.

The Court concludes that Dr. Hopkins is likely to succeed on his claim that the Tissue Disposal Mandate is vague such that it unconstitutionally deprives Dr. Hopkins of his due process rights. Based on the record before it at this stage of the proceeding, the Court is unclear as to the scope of the obligations imposed upon women seeking abortion and miscarriage care and/or Dr. Hopkins regarding "reasonable efforts" to locate an "absent" "parent" or "other members of the class" of "grandparents." The Tissue Disposal Mandate fails to provide Dr. Hopkins or enforcement authorities with "fair notice of conduct that is forbidden or required." *Fed. Commc'ns Comm'n.*, 567 U.S. at 253, 132 S.Ct. 2307.

3. Irreparable Harm

*68 [64] Enforcement of the Tissue Disposal Mandate will inflict irreparable harm on Dr. Hopkins and the fraction of women unduly burdened by the Mandate for whom there is no adequate remedy at law. It is well-settled that the inability to exercise a constitutional right constitutes irreparable harm. *See Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury.") (citations omitted); *accord Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (quoting *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L.Ed.2d 547 (1976)).

In the absence of an injunction, the fraction of women impacted by the Mandate would be unduly burdened in their right to abortion by the substantial obstacles created by the Tissue Disposal Mandate, and Dr. Hopkins likely would be denied due process as a result of the statute's vagueness. ***Whole Woman's Health***, 136 S.Ct. at 2309–10.

Therefore, the second requirement for an order preliminarily enjoining enforcement of the Tissue Disposal Mandate is satisfied.

4. Balancing Of Harms

[65] In the absence of an injunction, the fraction of the women impacted by the Mandate would be unduly burdened in their right to abortion by the substantial obstacles created by the Tissue Disposal Mandate, and Dr. Hopkins likely would be denied due process as a result of the statute's vagueness. ***Whole Woman's Health***, 136 S.Ct. at 2309–10. Whereas, if an injunction issues, a likely unconstitutional law passed by Arkansas legislators will not go into effect. The threatened harm to Dr. Hopkins and the women unduly burdened by the Mandate clearly outweighs whatever damage or harm a proposed injunction may cause the defendants.

5. Public Interest

[66] It is in the public interest to preserve the *status quo* and to give the Court an opportunity to evaluate fully the lawfulness of the Tissue Disposal Mandate without subjecting Dr. Hopkins, or the fraction of women impacted by the Mandate, or the public to any of the law's potential harms.

It is therefore ordered that Dr. Hopkins's motion for preliminary injunction is granted to the extent that defendants are preliminarily enjoined from enforcing the provisions of Ark. Code Ann. § 20–17–801(b)(1)(B); Ark. Code Ann. § 20–17–801(b)(2)(C); Ark. Code Ann. § 20–17–802; and including but not limited to Ark. Code Ann. § 20–17–802(f) which subjects a physician who violates the law to criminal penalties.

V. Security

Under Federal Rule of Civil Procedure 65(c), a district court may grant a preliminary injunction "only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." Fed. R. Civ. P. 65(c). In these proceedings, defendants have neither requested security in the event this Court grants a preliminary injunction nor presented any evidence that they will be financially harmed if they were wrongfully enjoined.

The Court waives the bond requirement under Federal Rule of Civil Procedure 65(c). Dr. Hopkins is serving a public interest in acting to protect constitutional rights related to abortion. Defendants will not be harmed by the order to preserve the *status quo*. Therefore, the Court will not require the posting of a bond. *See Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of Eng'rs*, 826 F.3d 1030, 1043 (8th Cir. 2016). For these reasons, the Court declines to require security from Dr. Hopkins.

IV. Conclusion

*69 For the foregoing reasons, the Court determines that Dr. Hopkins has met his burden for the issuance of preliminary injunctions for the challenged Mandates. Therefore, the Court grants Dr. Hopkins's motion for preliminary injunction. The Court hereby orders that defendants, and all those acting in concert with them, are preliminarily enjoined from enforcing the requirements of:

(1) the D & E Mandate, more specifically Ark. Code Ann. § 20–16–1803 and Ark. Code Ann. § 20–16–1805 which imposes criminal penalties on a person who violates Ark. Code Ann. § 20–16–1803(a);

(2) the Medical Records Mandate, more specifically Ark. Code Ann. § 20–16–1804(b)(2)(A) and (b)(2)(B); § 20–16–1805 which imposes criminal penalties on a physician or other person who violates § 20–16–1804(b)(2)(A) and (b)(2)(B); and § 20–16–1806 to the extent it permits a physician to have his or her medical license suspended or revoked for violating § 20–16–1804(b)(2)(A) and (b)(2)(B);

(3) the Local Disclosure Mandate, more specifically as to Non–CMA Teenage Patients the requirements of Ark. Code Ann. § 12–18–108(a)(1); the Arkansas State Crime Laboratory Rules prescribed to implement the amended law, Ark. Admin. Code § 171.00.2 (2013); and Ark. Code Ann. § 12–18–103(c) which subjects a physician who violates Ark. Code Ann. § 12–18–108(a)(1) to license suspension or revocation and other disciplinary penalties, Ark. Code Ann. § 17–95–409 (2009); and

(4) the Tissue Disposal Mandate, more specifically Ark. Code Ann. § 20–17–801(b)(1)(B); Ark. Code Ann. § 20–17–801(b)(2)(C); Ark. Code Ann. § 20–17–802; and including but not limited to Ark. Code Ann. § 20–17–802(f) which subjects a physician who violates the law to criminal penalties.

Further, defendants are enjoined from failing to notify immediately all state officials responsible for enforcing these requirements, about the existence and requirements of this preliminary injunction. This preliminary injunction remains in effect until further order from this Court.

So ordered this 28th day of July, 2017 at 11:20 p.m.

All Citations

--- F.Supp.3d ----, 2017 WL 3220445

Footnotes

1 As Dr. Hopkins points out, H.B. 1032 and H.B. 1434 amend Arkansas Code Title 20, Chapter 16 to add additional subchapters. Each bill numbers its first additional subchapter as 20–16–1801 and continues numbering subchapters consecutively. For clarity, Dr. Hopkins refers to the subchapters as numbered in their respective bills, even though it is anticipated that this is a drafting error and that subchapters in the proposed bills will be added using consecutive, not concurrent, numbering.

2 The Court uses the term "standard D & E" to distinguish it from "intact D & E," sometimes referred to as "D & X," which involves dilating the cervix enough to remove the whole fetus intact. "Intact D & E" is banned under the Federal Partial–Birth Abortion Ban Act of 2003, unless fetal demise is induced before the procedure. *See Gonzales v. Carhart*, 550 U.S. 124, 127 S.Ct. 1610, 167 L.Ed.2d 480 (2007) (upholding the federal partial-birth abortion ban). The Court also uses the term "standard D & E" to refer to the procedure that does not include induced fetal demise.

3 The Court rejects the defendants' expert Richard A. Wyatt, M.D.'s assertion that potassium chloride injections are "no more difficult than amniocentesis." (Dkt. No. 25–4, ¶ 6). Dr. Wyatt professes no expertise in the area of potassium chloride injections (Dkt. No. 25–4, ¶ 1). His assertion directly contradicts the cross examination testimony of Joseph R. Biggio, Jr., M.D., defendants' other expert, who testified at a hearing in a case involving a similar Alabama law and who is trained to perform and trains other physicians to perform such highly specialized procedures (Dkt. No. 32–3, Biggio Cross, at 134, 139–41).

4 Defendants do not argue that the D & E Mandate is designed to avoid fetal pain. Based on record evidence submitted by defendants, according to at least one study defendants submitted, fetal pain is not a biological possibility until 29 weeks, well beyond the range of standard D & E procedures (Dkt. No. 23–6, at 3).

5 Defendants suggest, without evidentiary support in the record, that physicians may rely on suction to cause fetal demise so as to avoid liability in the second trimester (Dkt. No. 23, at 31). The Court rejects that assertion based on record evidence (Dkt. No. 32–1, ¶ 5).

6 Defendants' expert, Dr. Biggio, has less practical experience and significantly less expertise than Dr. Hopkins's experts. Specifically, Dr. Biggio's testimony on cord transection "was largely theoretical and not based on experience." *W. Ala. Women's Ctr.*, 217 F.Supp.3d at 1339 n.24.

7 The Court observes and agrees with Dr. Hopkins that, at a minimum, defendants' arguments on this point are inconsistent. Although defendants contend the injection of digoxin would satisfy the scienter requirement even if ineffective, defendants also argue that before proceeding with D & E the physician would have to "employ other methods for ensuring the fetal demise including cutting the umbilical cord." (Dkt. No. 23, at 42; Dkt. No. 32, at 38–39).

8 The Court observes and agrees with Dr. Hopkins that defendants later argue that the scienter requirement protects only a physician who proceeds with D & E not realizing that an attempted demise has failed and not detecting a continuing heartbeat (Dkt. No. 23, at 42; Dkt. No. 32, at 40–41).

9 Even if this Court were to take the position that the D & E Mandate would impact only standard D & Es performed from 14.0 to 18.0 weeks LMP, 407 of the 638 women still would be impacted. 64% of these 638 women would experience a substantial obstacle to abortion. The Court notes that these figures would apply if there is a scienter requirement in the D & E Mandate; defendants maintain that, after 18.0 weeks LMP in Arkansas, the digoxin that is administered would be sufficient to comply with a scienter requirement in the D & E Mandate.

10 When confronting a constitutional flaw in a statute, a federal court must "try not to nullify more of a legislature's work than is necessary." *Ayotte*, 546 U.S. at 329, 126 S.Ct. 961. It is preferable "to enjoin only the unconstitutional applications of a statute while leaving other applications in force, or to sever its problematic portions while leaving the remainder intact." 546 U.S. at 329, 126 S.Ct. 961 (citations omitted). Severability is a matter of state law. *See Russell v. Burris*, 146 F.3d 563, 573 (8th Cir. 1998). Under Arkansas law, "an act may be unconstitutional in part and yet be valid as to the remainder." *Ex Parte Levy*, 204 Ark. 657, 163 S.W.2d 529 (1942). In determining whether a constitutionally invalid portion of a legislative enactment is fatal to the entire legislation, the Supreme Court of Arkansas looks to "(1) whether a single purpose is meant to be accomplished by the act; and (2) whether the sections of the act are interrelated and dependent upon each other." *U.S. Term Limits, Inc. v. Hill*, 316 Ark. 251, 872 S.W.2d 349, 357 (1994). Applying this standard, the Court satisfies itself that this type of challenge solely to the Medical Records Mandate of the statute is acceptable.

11 The Court notes that defendants seem to have misconstrued Dr. Hopkins's bases for a preliminary injunction as to the Medical Records Mandate. While Dr. Hopkins does state in his complaint that the Medical Records Mandate's medical records requirement violates a patient's right to privacy under the Fourteenth Amendment (Dkt. No. 1, ¶ 136), Dr. Hopkins does not move for a preliminary injunction on those grounds (Dkt. No. 2, at 31). Thus, the Court will take defendants'

arguments pertaining to informational privacy with respect to the Medical Records Mandate and apply them to the law on which Dr. Hopkins moves for a preliminary injunction on those grounds—the Local Disclosure Mandate.

12 As an aside, there is no record evidence that abortions in Arkansas have been sought based solely on sex (Dkt. No. 5, ¶ 30; Dkt. No. 6, ¶ 22). The Court has not relied on this observation in reaching its determination regarding the burden the Medical Records Mandate imposes.

13 The Court notes that under the informed consent provision of the Arkansas Woman's Right to Know Act, codified at Ark.Code Ann. §§ 20–16–901 through 908, before the day of an abortion, a physician must tell the woman seeking an abortion the "probable gestational age of the fetus." *See* Ark.Code Ann. § 20–16–901. The Woman's Right to Know Act further provides that " '[p]robable gestational age of the fetus' means what in the judgment of the physician will with reasonable probability be the gestational age of the fetus at the time the abortion is planned to be performed." Ark.Code Ann. § 20–16–902(9).

14 Arkansas law makes a distinction if the victim is above or below the age of 14. Under Arkansas law, if the victim is below the age of 14, in a prosecution for statutory rape, the statute does not create a presumption of intent depending on the victim's age. Proof of intent regarding the victim's age is not required because statutory rape is a strict liability crime, although there are certain affirmative defenses available depending on the age of the accused. Ark. Code Ann. §§ 5–14–102(b), 103(a)(4); *see also Gaines v. State*, 354 Ark. 89, 118 S.W.3d 102 (2003).

15 Several Courts have held that a woman's private sexual matters warrant a constitutional protection against public dissemination. *See Bloch v. Ribar*, 156 F.3d 673 (6th Cir. 1998) (holding that a rape victim has a fundamental right to privacy in preventing government officials from gratuitously and unnecessarily releasing the intimate details of the rape where no penalogical purpose is being served); *Eastwood v. Dep't of Corrections*, 846 F.2d 627 (10th Cir. 1988)(stating that the right to privacy is implicated when an individual is forced to disclose information regarding personal sexual matters); *Thorne v. City of El Segundo*, 726 F.2d 459 (9th Cir. 1983)(stating the interest [the plaintiff] raises in the privacy of her sexual activities are within the zone protected by the Constitution).

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